PROPOSED VETERANS' ADMINISTRATION BUDGET FOR FISCAL YEAR 1986

HEARINGS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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VETERANS' ADMINISTRATION BUDGET FOR FISCAL YEAR 1986

WEDNESDAY, FEBRUARY 20, 1985

House of Representatives,
Committee on Veterans' Affairs,
Washington, DC.

The committee met, pursuant to notice, at 9 a.m., Hon. G.V. (Sonny) Montgomery (chairman of the committee) presiding.

Present: Representatives Montgomery, Edgar, Mica, Applegate, Dowdy, Evans, Kaptur, Mollohan, Penny, Staggers, Rowland of Georgia, Bryant, Gray, Kanjorski, Hammerschmidt, Solomon, McEwen, Smith of New Jersey, Burton of Indiana, Sundquist, Bilirakis, and Rowland of Connecticut.

The Chairman. The committee will come to order.

The Chair recognizes the gentleman from Florida.

Mr. Mica. Mr. Chairman, I just want to say it's a pleasure to be here this morning. I do have to step out of the meeting room for just a few moments and will be back as quickly as I can. Thank you.

The Chairman. Thank you, sir.

We are pleased to have the Administrator, Harry Walters, and the members of his staff to review the Agency's proposed 1986 budget. We welcome the Administrator and also the staff members with him.

Mr. Administrator, before hearing your testimony, we would like to do something that we have been looking forward to, something very pleasant, something that makes life worthwhile, we think. We would like to have Mr. Fleming escort Dorothy Starbuck to the rostrum.

[Applause.]

While Congress was out of session, Dorothy Starbuck, who was the Chief Benefits Director of the Veterans' Administration, one of the three key jobs in the Veterans' Administration, retired on us on December 21. We were not able to honor her at that time. At this time we want to honor Dorothy Starbuck. She served for many years at the Veterans' Administration. In fact, she served with every Administrator except the first one appointed.

She has appeared before this committee many, many times. She handles herself so well. She doesn't talk a lot. She just tells us what she wants us to hear, and then she waits on the questions. She gets by with it and she has done that for several years and it always works out.

We are very proud of Dorothy Starbuck. In fact, she looks younger and younger to me since she has retired. Dorothy, we are certainly happy to honor you today before the first full meeting of this committee.

I would like at this time to introduce our very capable ranking minority member of the full committee, Mr. Hammerschmidt, who will read the resolution for the hearing record. The Chair recognizes the gentleman from Arkansas.

Mr. **HAMMERSCHMIDT**. Thank you, Mr. Chairman. I join you in welcoming a great and highly respected friend of ours and of this committee and of the entire Congress and of all of our Nation's veterans across this country and around the world. It is a distinct honor to present this resolution:

> Whereas, Dorothy L. Starbuck distinguished herself as a member of the United States Army from 1942 to 1946, during which period she served overseas for two years in France and Germany, being separated as a captain; and
>
> Whereas, following service, she has served the Veterans' Administration during the tenure of 11 Administrators for almost 40 years, and
>
> Whereas she gained national attention as the first female to be appointed to a number of managerial positions, including the first Regional Office Director and the first Chief Benefits Director, and
>
> Whereas as Chief Benefits Director, she was responsible for the administration of one of the most comprehensive benefits programs in Federal Government, through a network of 58 regional offices, from Manila, Philippines Islands, to San Juan, Puerto Rico, and
>
> Whereas she received many awards and honors, including the President's Award for Distinguished Federal Civil Service presented in 1978 by President Jimmy Carter, and the Distinguished Executive Award by President Ronald Reagan in 1982,
>
> Now, Therefore, be it resolved that the Committee on Veterans' Affairs of the U.S. House of Representatives, on this 20th day of February 1985, commends Dorothy L. Starbuck for her dedication in fulfilling the Nation's commitment to its veterans and their families and extends its highest commendation for her example of leadership and devotion in carrying out the Veterans' Administration's mission of serving American veterans and their families throughout the world with compassion and dignity.
>
> Signed, G.V. (Sonny) Montgomery, Chairman, and John Paul Hammerschmidt, Ranking Minority Member.

Thank you, Mr. Chairman.

[Applause.]

The **CHAIRMAN**. The Chair doesn't do this often, but the Chair would like to turn over the gavel to Dorothy Starbuck for any comments she would like to make.

Dorothy.

Miss **STARBUCK**. I finally know how it feels to be here and not out there.

Mr. Chairman, Mr. Hammerschmidt, members of the committee, I am overwhelmed by the honor that you have done me today, and I can only say that in the years that I served as the Chief Benefits Director, it was always my distinct pleasure to work with the committee and to serve you as you pursued the benefits that are so worthy for our veterans.

Mr. Chairman, I am humbled by your honor. Thank you so much.

[Applause.]

The **CHAIRMAN**. Thank you again, Dorothy.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

The CHAIRMAN. Mr. Administrator, before hearing from you, I have a few remarks about the President's budget. I will have more to say later when we address some of the issues in more detail following your testimony.

Let me start by responding to the budget in a positive way. First, I want to congratulate you for changing the President's feelings about providing a cost-of-living increase in compensation rates. It had been widely reported in the news media that although the President had stated that Social Security beneficiaries would get a rate increase effective January 1, 1986, the budget would not contain funds for like increases in compensation and pension benefits. Denying these increases would have required this committee to disconnect the veterans pension program COLA from Social Security, since increases for these two programs are automatically indexed by law. This would have been extremely difficult for us to do.

In addition, Congress would have been asked to grant a cost-of-living increase for those drawing Social Security while denying an increase for veterans drawing compensation for disabilities resulting from active duty service. This would have made no sense at all. Apparently you made a direct appeal to the President and we are very pleased with your results. We note that moneys for a 4.1 percent COLA for both the compensation and pension programs are contained in this budget.

Now let me turn to several items with which I have some personal problems. First, I note the President is again attempting to consolidate all major adjudication functions at 58 regional offices into three centralized offices. This is the same plan we rejected in 1981. It will not work for a variety of reasons, and I expect the committee to have more to say about this later. The last time the administration attempted to do this, Congress enacted legislation requiring a detailed plan justifying the action and that the plan be submitted to the Congress before proceeding with its implementation, giving Congress time to review the plan and to take possible action to prevent the consolidation.

I ask unanimous consent to include at this point in the record a letter Mr. Hammerschmidt and I sent to the Administrator, advising him that such consolidation would not be in compliance with current law, if implemented, as set out in this budget request.

[The referred to letter appears at p. 112.]

The CHAIRMAN. The second item that concerns me greatly is the proposed plan to charge each veteran seeking a VA home loan a 5-percent user fee in order to obtain the loan. On a $65,000 VA guaranteed loan, the veteran would be required to pay about $3,000 just to be able to obtain the loan. This would be most unfair, in my view, and I will propose that the committee oppose it. Such a fee would go against a segment of our veteran population that never comes to the VA for anything except to purchase a home. We have already imposed a 1 percent fee on all non-service-connected veterans who come to the agency for a loan. I didn't like the idea when we first imposed the fee, and I don't like it any better today. We did it on a temporary basis to help with the deficit problem. I cannot agree to increase the fee any further, nor will we make it permanent.

The third thing that disturbs me is the reduction in acute care beds and the reduction of 4,000 personnel for veterans' health care. This is not the time to be reducing beds in VA hospitals. We have just received a needs assessment from the agency spelling out the demands that must be met for the care and treatment of our older veteran population—mostly World War II veterans—for the remainder of this century. It shows that more beds, acute and long-term, will be needed in and out of the VA to take care of the expected demand. I know we will have to make do with less for the time being; therefore, we will be unable to increase the number of both beds and personnel as rapidly as we should due to the current budget situation. Nonetheless, we can't reduce our current service level, either. I will be anxious to hear from you as to how the agency plans to deal with the aging veteran problems with the proposed reductions contained in this budget.

I ask unanimous consent that I be allowed to place in the record at this point a letter I recently sent to Dave Stockman concerning my views on the health care issue in response to remarks he made on Meet the Press.

[The referred to letter appears at p. 114.]

The CHAIRMAN. I personally see no reason why we can't proceed with the administration's request to change the law that now allows a veteran to be treated in VA facilities at age 65 even though he or she may be able to pay for the cost of such treatment elsewhere. Frankly, it is common practice for editorial writers to inform the public about the thousands of older affluent veterans who occupy beds in VA facilities every day and how much it is costing the taxpayers. This is nonsense. Affluent veterans are not in VA hospitals in great numbers and that is why I am not opposed to changing the law making veterans age 65 and over sign a statement that they are unable to pay for their care outside the VA, the same as veterans below that age. I have visited many VA hospitals since becoming a member of this committee and never have I found a single one where veterans with substantial incomes occupied beds at VA expense.

I do take issue with those who say thousands of dollars will be saved if we repeal the 65-year-old provision. It will not save a cent. For every veteran 65 years of age or older who is displaced, thousands who are now being turned away because of lack of resources will be waiting in line to take their places.

Finally, I want to comment briefly on an issue not contained in the President's budget and which will not be before this committee—the taxing of VA compensation. Before leaving the Department of the Treasury, Donald Regan proposed to the President that VA compensation be taxed as part of his tax simplification plan, even though compensation is a tax-free benefit granted pursuant to title 38, United States Code. Rather than take the time of the committee to state my strong objections to such a proposal, I ask that my letter to the President dated January 9, 1985, be included in the hearing record,[1] as well as a copy of a letter Mr. Hammerschmidt and I have sent to Secretary Jim Baker, who will now be the administration's chief spokesman on the tax reform package.[2] I am hopeful Secretary Baker will take a different view on this matter and that he will convince the President not to ask the Congress to change the current law.

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[1] See p. 116.

Mr. Administrator, these are but a few of the observations I want to make at this time. If you could limit your remarks to 15 minutes, that would certainly help the members. We do have the Prime Minister of Great Britain here at 11 o'clock in a joint session. I do appreciate very much the members who are here this morning. We didn't know it when we scheduled this meeting, but there will be no votes in the House of Representatives this week. We are proud of the members who are here this morning to hear your testimony.

Before you make your remarks, I would like to recognize Mr. Hammerschmidt.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman.

The committee has before it a Veterans' Administration budget request which raises many important and difficult issues. It recognizes it is imperative to address the national deficit, and it recognizes that the VA is not and should not be immune from that endeavor. As we examine the budget request, our committee must now make its independent assessment of it.

In that connection, I align myself with you, Mr. Chairman, in declaring that veterans' services and benefits should have a very high national priority. I am confident that our report to the House Budget Committee and our advice to the House Appropriations Committee will reflect that judgment.

Mr. Chairman, the administration has properly sent to Congress a lean and frugal budget. It reflects some changing missions in VA medicine, such as new medical activations and conversion of medical care beds to nursing care beds. It notes the needs of the aging veteran and it predicts a slight increase in the number of outpatients and inpatients treated. In actual medical dollars, the budget is up by $236 million to a total of $9.2 billion.

However, when the pay increase of January 1, 1985, and inflation are considered, and when other increased costs are taken into account, the medical budget request would seem to not be a real dollar increase but a decrease or standstill budget, thus showing that, in fact, the President's budget does recognize VA's role in deficit reduction and does require the VA to be an integral part of it.

Mr. Chairman, this budget calls for several significant things to be done which involve large sums of money. They involve veterans, dependents of veterans, and the entire administrative structure of the Veterans' Administration. They are: A 5-percent reduction in pay for all VA employees, grade reductions of employees at the GS-11 to GS-15 level, a savings of 1,916 positions in DM&S through management improvements, a savings of some 105 positions in the central office medical management staff and related functions, a reduction in research money, a transfer of certain automatic data processing activities from Fort Snelling, MN to Austin, TX, and transfer of such other activities from Los Angeles, CA to Hines, IL; the imposition of a means test for certain nonservice-connected veterans applying for medical care; the recovery of medical care costs from third parties; a proposed reduction in construction funds; a reduction in the number of cemetery employees; a proposal to increase user fees on GI loans from 1 percent to 5 percent; a proposal to transfer the VA prosthetic function from New York City to Washington, DC; and a proposal to have an extensive reorganization of the Department of Veterans Benefits for the large reduction of employees not only for fiscal year 1986 but also for the years thereafter.

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[2] See p. 119.

Incidentally, Mr. Chairman, this is a proposal which this committee rejected 4 years ago, and which I think we ought to again reject.

Finally, we have a proposal for a cost-of-living increase in compensation and pension for veterans and their dependents and survivors.

Mr. Chairman, these proposals deserve our committee's closest scrutiny. What are they really designed to accomplish? Will they save money, or will they cost money? What will be the effect on the quality of service? Did VA propose them, or were they imposed on VA? Are unsettled legal implications involved? What budget refinements will be needed if the Congress does not accept some of them?

When the question period comes, Mr. Chairman, I am sure we will want detailed answers from the Administrator and his associates as to each of these matters.

Mr. Chairman, I firmly believe that the veterans of this Nation and the organizations which represent them have made sizable contributions over these past few years to the solution of the Nation's financial problems. They have the right to be proud of that. Perhaps there is more to be done. I would therefore urge upon this committee a position of prudence, a position of realism, and a position of restraint. But just as important, Mr. Chairman, I would urge a position of high national concern for those programs for our Nation's veterans that have been so carefully crafted and nourished by the Congress over these past years under your careful guidance and gifted leadership.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you for that strong statement.

I would like to point out to the members of the committee that this committee in the past 4 years has certainly cooperated with this administration. We have slowed down spending by $1 billion in the last 4 years in veterans benefits, and we have hurt some of the programs that I was concerned about. But I think now is the time to take a good hard look at what this administration has sent up here.

I have instructed my staff to see if we can find ways to make savings without hurting the basic benefits for the veterans, certainly we want to look into that and cooperate. But as far as I'm concerned, we're going to go slow on what the President has recommended and sent up here in this budget.

Mr. Edgar.

Mr. EDGAR. Thank you, Mr. Chairman.

Mr. Chairman, I would like to ask unanimous consent to insert in the record my opening statement, along with a chart which shows the actual and real dollars expended over the last 10 years on veterans' programs.

The CHAIRMAN. Without objection.

[The statement of Mr. Edgar appears at p. 121.]

STATEMENT OF HON. BOB EDGAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. EDGAR. Mr Chairman, I want to commend you for not only holding this hearing but for your leadership within this committee over the years. You have done a good job of looking carefully at veterans' programs and making sure that the dollars we expend are expended and targeted to those veterans who have needs, and particularly to the service-connected-veteran who has problems.

I want to say that in my opening statement I share some very strong language in terms of concern in three basic areas: First, I am concerned about the disguised reduction in necessary staffing for the VA health care system, and I will ask some questions in that area.

Second, I am concerned about the legislative initiatives contained in the President's budget message. Our subcommittee has not scheduled hearings on these initiatives because the administration has not formally transmitted the proposals to Congress. These are very significant changes and I want to assure both the chairman and Mr. Walters that we intend to look very carefully and with the chairman's direction, go very slowly on those initiatives.

Finally, I want to indicate my strong concern about the information contained in the VA's report on caring for the older veterans and the lack of response within the President's budget initiative.

Now, I have a great deal of respect for Mr. Walters and his work, and I hope that he continues in that capacity for a long time. But I have a great deal of concern, frustration, and anger at some of the budget numbers that I see, and I will include some of that concern and anger in some of my questions—constrained, of course.

Thank you, Mr. Chairman.

The CHAIRMAN. Do any other members want to make a statement now? The Chair recognizes the gentleman from Pennsylvania.

STATEMENT OF HON. PAUL E. KANJORSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. KANJORSKI. Mr. Chairman, I want to congratulate you on holding these hearings today on the massive changes the administration has proposed in our Nation's veterans programs. We owe a great deal of gratitude to the millions of brave men and women who have willingly laid down their lives on the line to protect our Nation and for what it stands. It is only fitting that we meet to publicly discuss the issues of such great importance to those who have risked their lives and limb for their country.

I am proud of our veterans and proud to be their advocate here in Congress. It saddens and angers me to hear Mr. Stockman attack the benefit programs which our veterans depend on. We owe our lives and freedoms to these brave men and women. Pensions and disability aid are not handouts. The benefits they receive are their compensation for the sacrifices they have made on our behalf.

For the first time in our Nation's history the administration has proposed placing a means test on health benefits for veterans who are over 65. A half-million veterans will lose the important medical benefits they counted on receiving in their retirement years. The administration proposes this change in order to save money, but it has failed to calculate the effect it will have on other Federal health programs. The proposal will shift nearly 200,000 veterans into the Medicare system. In the end, this money saving plan could add an extra $600 million a year to the Medicare costs, thus wiping out any savings in the VA budget.

The administration also proposes to increase fivefold the fee veterans must pay to obtain VA home loan financing. For the average vet, this plan would add $3,000 to their borrowing cost and could deny them the chance to own their own home.

As a representative of an area still trying to work its way out of the last recession, I am particularly disturbed by the administration's proposal to eliminate the Emergency Job Training Program for Vietnam era veterans. This program has a proven record of success in developing job opportunities for veterans who have been hardest hit by the recession.

Mr. Chairman, I am outraged by the attitude that, once a soldier has done his duty to our society, we owe him no more. As a member of the Veterans' Affairs Committee, I will fight to honor the commitments we have made to our Nation's veterans and their families.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for his statement.

The Chair recognizes the Administrator.

STATEMENT OF HON. HARRY N. WALTERS, ADMINISTRATOR OF VETERANS AFFAIRS; ACCOMPANIED BY EVERETT ALVAREZ, JR., DEPUTY ADMINISTRATOR; PAUL T. BANNAI, CHIEF MEMORIAL AFFAIRS DIRECTOR; JOHN W. HAGEN, JR., ACTING CHIEF BENEFITS DIRECTOR; AND JOHN W. DITZLER, M.D., CHIEF MEDICAL DIRECTOR

Mr. WALTERS. Thank you, Mr. Chairman. I won't take 15 minutes, rest assured.

My formal statement will be submitted for the record. I have about 5 minutes of summary.

The CHAIRMAN. Without objection, so ordered.

Mr. WALTERS. Thank you, Mr. Chairman.

I think I would like to introduce my staff first, particularly for the new members of the committee.

The CHAIRMAN. Let the record show that Mr. Solomon was here, one of the ranking minority members, and he had to leave.

Go ahead, Mr. Walters.

Mr. Walters. Mr. John Hagan is our Acting Chief Benefits Director; Dr. John Ditzler is our Chief Medical Director; Everett Alvarez is our Deputy Administrator; and Paul Bannai is our Director of Memorial Affairs. Our Acting General Counsel, Bob Coy, sits behind me to my right.

I would like to tell you that I think your honoring Dorothy Starbuck today is a very nice thing to do. When she came to me and said she was going to retire, she asked me if she could be allowed to leave without any fanfare. I promised her I would not allow that to happen, and I can see you didn't let her down, either. She has received a lot of praise in 40 years of service to the Federal Government. I think it is worthwhile, Mr. Chairman, that you took your time and this committee's time to honor her this morning. We thank you.

The Chairman. Thank you, Mr. Administrator. This is one of the largest crowds we have had at a hearing, and I am sure a good part of that crowd was on account of Dorothy Starbuck.

Mr. Walters. Mr. Edgar, off the cuff, I would just like to say that General Bradley once said—and I quote—"I can't think of a job I would rather not have than Administrator of the VA, nor a job I would like to do better." Your comments about my staying on may be a bit sadistic on your part, I'm not sure. But I will take that with a good sense of humor and in the right spirit.

Mr. Chairman and members of the committee, I am grateful for the opportunity to appear before you today to discuss the Veterans' Administration's 1986 budget. When I was confirmed as Administrator of Veterans' Affairs, I said I would be the advocate for our Nation's veterans. In that regard, no budget can adequately repay our veterans for all they have done for America. However, I, like the veterans the VA supports, realize the Nation has a challenge confronting it. It's called the national deficit.

Veterans have always been willing to share in solving America's problems, so long as they were treated fairly in comparison to those who did not serve. This year's budget, in my view, does treat veterans fairly in relation to other Government activities. I believe this fact shows the importance the President places on veterans and veterans' benefits.

This year's budget calls for $27.1 billion in new budget authority, of which $26.3 billion is the appropriation request—$61.8 million for proposed legislation and $851 million is for permanent authorizations. The largest portion of the budget request continues to be in our benefits programs. Overall, the benefits request of $15.6 billion represents over 59 percent of the total request. The benefits program includes proposed legislation for a 4.1-percent rate increase which will be effective December 1, 1985 for compensation and pensions.

For medical care, this budget shows an increase of $236 million over the 1985 level for direct medical care. The employment level for direct medical care is projected to increase by 199 over an adjusted 1985 employment level of 191,849. Workload projections for the inpatient treatment and outpatient medical visits show increases over 1985.

This budget contains proposed legislation to restrict access to medical care, with regard to income levels, for those veterans over age 65. Their eligibility would be the same as veterans under age 65. Exempted from this reform would be service-connected veterans and certain categories of other veterans. This reform would restrict the use of the VA medical system by all nonexempt veterans whose income exceeds the eligibility level.

I believe this to be important legislation and ask your support in its passage. Need, not age, should be the critical factor in determining eligibility for non-service-connected veterans.

Legislation is also proposed to obtain third party reimbursement for the cost of medical care and treatment for veterans with non-service-connected disabilities. The VA already does this when it can and, in fact, collected some $20 million just last year.

Our request for general operating expenses includes $749 million and 18,681 average employment for the operations of the Department of Veterans Benefits, the Department of Memorial Affairs, and the various staff functions of our central office. The budget states that the VA will consolidate some of DVB's facilities. Now, this may happen, but we cannot tell at this time. An effort to develop a plan for modernizing the entire DVB operation has just begun. This plan will consider several alternatives, including consolidation. When it is completed, a decision will be made as to the best course of action to be taken concerning the Department of Veterans Benefits.

In the general administration activity, average employment reductions of 154 FTEE will be achieved through improved productivity and efficiencies in operations and will not reduce services provided. I propose closing data processing facilities. Their functions will be consolidated in Hines, IL and Austin, TX. The closure of the St. Paul and Los Angeles data processing centers and the Romney, WV message switching center, will reduce average employment by 113.

In the construction appropriation request, $712 million is included for medical facility projects, $18.9 million for the national cemetery program, $2 million for DVB, and $2 million for the Office of Data Management and Telecommunications, $500,000 for the year old emergency fund, and $35.3 million for expenses of the Office of Construction.

Of the total program request of $771.6 million, $160 million is made available from prior appropriations. Of the 33 major projects, initial construction funding is included for Philadelphia, PA, with funding for the main hospital building for Houston, TX, and renovations and replacement of buildings for Mountain Home, TN, also requested.

One other point I would like to make is that the outyear numbers for medical care are plugged numbers. They are not meaningful. National policy decisions must yet be reached, decisions which will affect the VA. Discussions leading to these decisions will be conducted in the sunlight, including the Veterans' Administration, veterans service organizations, and, of course, all other interested parties.

This briefly summarizes my opening remarks, Mr. Chairman. My staff and I will be pleased to answer your questions regarding the 1986 budget estimates for the VA. Thank you.

[The statement of Harry Walters appears at p. 125.]

The CHAIRMAN. Thank you, Mr. Administrator, for getting right to the point. It shows you don't have to have long testimony to cover the subjects, and it does give members the opportunity to ask questions.

I would like to say that the budget is up here and we don't know exactly what will happen, but we do know, Mr. Administrator—and we appreciate what you did—that there was talk at the White House level that Social Security recipients would receive a cost-of-living increase in the 1986 budget and that did not include veterans compensation, even though the pensioners are tied in by law with Social Security. We were told you did go to the White House and then the compensation and pension of veterans was included in that proposal. We know that and we want to thank you for moving ahead and going down to the White House and pleading for the veterans.

Mr. WALTERS. The President made a very wise decision, Mr. Chairman.

The CHAIRMAN. Thank you.

Before the Chair recognizes Mr. Hammerschmidt, the Chair will enforce the 5-minute rule, and also the way the members came into the committee meeting we will go in that order. That seems to be the best way to do it. We can move right along and every member will have a chance to ask questions and make comments.

Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. Chairman, due to the time constraints we're operating under, with the House convening at 10 o'clock—Mrs. Thatcher will be there at 11 o'clock—we will probably have to leave here about 10 o'clock if we get a quorum call.

I would ask unanimous consent that I and all members of this Committee be allowed to submit questions to the Administrator for his response. We only have until March 6 to markup our budget resolution, so we would very much appreciate an early response from the VA so we can have the benefit of their thinking as we make our judgments in the budget resolution.

The CHAIRMAN. Without objection, so ordered. But I would like to get some key questions answered in the open hearing.

Mr. HAMMERSCHMIDT. Of course. We will ask what we can. I have some 50 questions, myself, but it would be impossible to cover them all this morning.

Mr. Administrator, there have been widespread news stories about free care of veterans over age 65. The stories have indicated that these veterans are sometimes affluent. I wonder if you would please comment on VA's experience in this area.

Mr. WALTERS. Mr. Hammerschmidt, the latest census data taken on that particular subject was in 1979, and it was the Harris Survey that was done at that time. The data does not reflect great numbers of affluent veterans visiting the hospital care system at that point in time.

I have ordered a study to be done on a census basis, not the same Harris Survey, but data that is available to the VA. The Deputy Chief Medical Director is in charge of that survey and information should be available within the next 2 to 3 weeks.

Is that correct?

Dr. DITZLER. We will have some data, yes, sir.

Mr. WALTERS. Some data will be available, but we don't know how extensive or conclusive it will be.

If I might; in answer to that question, I have been distressed by that view as well. Two things bother me about that. One, it says "free." I don't think veterans necessarily get anything free. They have earned their right to come to the medical care system. Second, the law that allowed for the care of veterans over age 65 was passed in 1970, and I am sure it was passed in the right spirit, without having to defray costs. At this point in time, though, we have to look in terms of not having infinite resources; we have finite resources. With that in mind, I think the law is now becoming discriminatory to those veterans under age 65, and those would include the majority of our Vietnam veterans. I find, as Administrator, that to be a very unfair position for the VA to be in, to administer the law accordingly. This is why I have asked the Congress—and I subscribe to this piece of legislation—to look at that law and hopefully come to grips with it on the basis of administering the law in a fair and equitable manner to all of our veterans.

Mr. HAMMERSCHMIDT. I appreciate that response. Of course, some of us on this committee, including the chairman and myself, certainly remember when we changed the law in 1970. We did open up the law to a great many more veterans for some of the benefits that are creating great distress right now.

Let me ask you, Mr. Administrator, what kind of a means test will the VA be proposing? I am concerned about the cost of administering such a test and about the possibility that it won't save much, if any, money. How many people and how much money will it take in fiscal 1986, and then in subsequent years, to do the administrative things necessary to have a means test?

Mr. WALTERS. I don't have the exact numbers on the cost of administering the test, but I will supply those for the record, Mr. Hammerschmidt.

[Subsequently, the Veterans' Administration furnished the following information:]

The Administrative costs are under development and will be submitted shortly with the legislative proposal.

Mr. HAMMERSCHMIDT. Would you also supply for the record the criteria of the means test, if you can't give that to us today?

Mr. WALTERS. The criteria for the means test are on my desk this morning, on the way to the Office of Management and Budget, and then coming up here in legislation. I am just not free to discuss it right now. We will have it to you hopefully within a few weeks.

Mr. HAMMERSCHMIDT. Let me change to another subject.

Do you have any waiting lists anywhere in the country for service-connected veterans except for elective surgery?

Mr. WALTERS. Not that I'm aware of. Dr. Ditzler?

Dr. Ditzler. I'm not aware of any service-connected veterans who are on a waiting list for hospital care.

Mr. Hammerschmidt. We also hear stories of thousands of non-service-connected veterans being turned away from the system because of lack of funding. I wonder if you would please comment and tell us the facts as you know them.

Mr. Walters. Well, the latest survey indicates we are turning away approximately 20,000 non-service-connected veterans a month. We don't have accurate data as to what the mix of those veterans is and the reasons why they're being turned away.

Dr. Ditzler may want to add to that.

Dr. Ditzler. Mr. Chairman, we have spotty samples from around the country which do show we are turning away applicants for care. Whether those were applicants for inpatient care or ambulatory care is part of the issue. Approximately 17 percent of those individuals had some form of other health care support to which they could have turned.

Of the total applicants, about 80 percent of them were eventually cared for, but we do not have the finite details to specifically answer your question.

Mr. Hammerschmidt. Mr. Chairman, I see my time is up. Thank you very much.

The **Chairman.** Before recognizing Mr. Applegate, let the Chair comment. Dr. Ditzler, say a non-service-connected veteran comes in to be admitted, and it's an emergency, he or she is in trouble. You do admit them, is that correct?

Dr. Ditzler. That is correct. I know of no emergency case that is being rejected, whether it be service-connected, non-service-connected, or whatever the category of veteran.

The **Chairman.** Mr. Walters, on Mr. Hammerschmidt's question, I think what you're telling this committee is that age of 65 is no magical number and that you would prefer that age 65 be eliminated and you think you can administer, as far as means testing, and do a better job with that age of 65 or over being eliminated?

Mr. Walters. Yes, Mr. Chairman. It does one other thing. I think the VA has come under criticism, as the veterans' service organizations have in the last 3 or 4 months, from columnists including Andy Rooney, I might add, for taking care of middle class and wealthy America. That simply has not been the case. In my trips to the hospitals and in the data we have available to us, it does not indicate, at this point in time at any rate, that we're taking care of middle class America.

But as the aging veteran numbers begin to swell, there will be a significant number of veterans over the age of 65 who can, by law, access the VA medical care system and, with the VA having finite resources, may displace a veteran who has a need but is under the age of 65. That is not fair to that veteran under the age of 65, in my view.

The **Chairman.** The Chair recognizes the very capable chairman of the Subcommittee on Compensation, Pension and Insurance, Mr. Applegate of Ohio.

Mr. Applegate. Thank you very much, Mr. Chairman.

Mr. Walters, it is nice to have you here before the committee. Is there a continuance in the reduction of the number of beds in the hospitals? Does that present a problem as far as taking care of our non-service-connected veterans?

Mr. WALTERS. Well, there has been an ongoing program in the VA for a number of years now to convert hospital beds, when possible, to nursing home care beds. That is an ongoing concern. In the care of the Aging Veteran Report, if it shows one thing as a salient item, it is the fact that the nursing home and extended care facilities are going to be at a premium in the years to come. The debate as it exists today, and has been for a number of years, is how many nursing home care beds do we need, and how many acute care beds can we convert and still supply the acute care needs to our veterans who are ill. The debate is not yet complete by any stretch of the imagination, and that is why I said the outyear numbers in this budget are not to be considered as meaningful.

Mr. APPLEGATE. I see the President decided not to touch the Social Security COLA and has provided veterans with a cost-of-living increase. Earlier he indicated that veterans would not be included. But I am very pleased, as has been pointed out, that he recognized our disabled veterans who fought our wars have an equal right to that consideration. I think that's good.

I am concerned about your plans to consolidate the main functions of the regional offices into three locations. It appears, at least to me, that the plan doesn't really make much sense and I wanted to know more about it.

In your letter to Chairman Montgomery, which was dated February 1, it looks like you have an idea but no definite plan. I would like to know just where the three super offices would be located, but I won't necessarily ask you this question at this time because, as you said, you wouldn't be able to tell us about those locations until perhaps July.

My first question is about whether or not you believe that you can consolidate the offices in fiscal year 1986. The Chairman and Mr. Hammerschmidt, in their letter to you of February 11, advised you that you had not complied with Section 210(b) of title 38 requiring a detailed plan for reorganization to be submitted at the same time as the budget submission.

In view of this exchange of correspondence, do you believe now that you can legally proceed with the organization in 1986?

Mr. WALTERS. One thing I am not is an attorney, and I think the Lord has blessed me in that regard. But at any rate——

Mr. APPLEGATE. Both of us.

Mr. WALTERS. Not to be trite or try to be cute, I don't know the legal implications of that. But I would like to address your question with a statement, that perhaps has a little more meaning in terms of the consolidation proposal.

Frankly—and I must be frank about it because that's the only way I know how to be—the VA did not ask for a consolidation. It was passed back to us in the budget. So we have not had time to consider all the aspects of a plan for consolidation. To be even more frank with you, the fact of the matter is that the VA, under my direction, has been working with a consultant, McManis and Company, to develop a mission statement for automation and modernization of all of our departments.

The Department of Veterans Benefits is obviously a very important part of that modernization program. We just recently have stated a goal and a mission. We have developed objectives with each one of our department heads. Now we find that the consolidation, as proposed in the OMB budget, may be at loggerheads with that very study.

So I met with OMB and we discussed that matter. The resolution of it is as follows: We intend to consider modernization first as a goal, with the outcome of modernization, the automation process, determining consolidation or not determining consolidation, depending upon whether or not that plan makes any sense. The same amount of time is going to be required to determine whether consolidation is good, as it would be to determine whether or not automation should drive consolidation as well. So we are going to look at that entire area and we're going to look at it on the basis of what I think is good management. OMB has conceded that is a good way to approach it.

We are not suggesting that consolidation will not be the outcome. It could very well be the outcome and, in fact, if it is, and if that's where the benefits can be delivered best and that's how we can save and be more efficient, then we will recommend that as our plan.

Mr. APPLEGATE. Mr. Chairman, that red light is on. Does that mean I'm out of time?

The CHAIRMAN. Yes, that's the ruling of the Chair. [Laughter.] You can wait around 3 hours and the Chair would be glad to recognize you again.

Mr. APPLEGATE. It seems like I just got started. I guess I was having that much fun.

I have a number of questions that I would like to ask, and I will throw these questions out to you, Mr. Walters, in writing. I would ask that you respond. That way, because of our time constraints, we can handle that much easier, because I did have some very sensitive questions I wanted to get out.

Let me just say again, thank you very much for coming. I know we do have some differences. They are very light. I think you have done a good job as the Administrator and I am glad to hear your testimony.

Mr. WALTERS. Thank you, sir.

The CHAIRMAN. I think your question was certainly appropriate. The Administrator said some of these areas have been recommended and it didn't come from him but came from OMB, which is important for this committee to know.

Mr. Molinari of New York. You see, when you get here on time——

Mr. MOLINARI. Thank you, I see that it pays dividends. Thank you, Mr. Chairman.

Mr. Walters, only a few years ago the VA estimated that there would be a several hundred million dollar a year return to the Government if third-party reimbursement became law. Now, in looking at the budget, you are estimating $65 million to be the savings.

Can you account for the wide disparity in those figures?

Mr. WALTERS. I can't off the top of my head, but I will supply it for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

We are still estimating several hundred million dollars will be recovered from third party recovery. However, the $65 million in the budget allows, once legislation is passed, for health insurance policies to gradually be rewritten eliminating the exclusionary clause as they are renewed or renegotiated throughout the year. Additionally, we expect that there would be some lag time the first year after passage of the legislation before actual collections "catch up" with amounts billed. For these reasons, we believe that $65 million is a realistic estimate of reimbursements for the first year after passage of our proposed legislation. In subsequent years, recoveries are estimated to increase substantially.

Mr. MOLINARI. I had asked that question of Dr. Ditzler last week, and I think an answer to it would be of great interest, certainly to this Member. Now let me ask another question.

Would you present for the record a legal document with respect to the law and third party reimbursement for veterans medical care? Please include reference to the constitutional issue that's involved. We are told the likelihood is that there will be extensive litigation insued if this proposal is adopted, but I think it is one that is worthwhile looking into and I know the Committee would like to get a better reading on it, if we could.

[Subsequently, the Veterans' Administration furnished the following information:]

The General Counsel's Office subsequently indicated that while no indepth legal analysis has been prepared or is available with respect to this proposal, they did have discussions with the Department of Justice in drafting it. While some litigation might be anticipated, inasmuch as it applies to contracts prospectively, it is believed that any litigation can be successfully defended.

Mr. MOLINARI. I just have one other question. Why is it that the VA nursing home per diem is higher than the private sector?

Mr. WALTERS. Dr. Ditzler.

Dr. DITZLER. That's a very complex question. It relates in part to our cost distribution methodology. We include in the RCS-10-0141, previously RCS-14-4 which is the reporting system wherein we account for all costs in the health care system, an account for nursing homes. Included in the account are a pro rata amount of hospital administration, as well as a pro rata amount of the many departments of the hospital, such as medicine, radiology, laboratory, building management, engineering, et cetera. All go into the nursing home cost.

Another reason is that in our VA nursing homes we provide access to the types of care not expected to be provided by community facilities under contract with the VA. We also believe that we provide a greater number of nursing care hours per patient per day and have a greater proportion of licensed nursing personnel in our VA nursing homes.

So I think that if one were able to compare on the same basis, there would not be near the difference.

Mr. MOLINARI. How about doing that for us. How about preparing a comparison chart for us on VA nursing home care as opposed to private nursing care, factoring in the items that you have discussed, so we can have an intelligent way of comparing the cost figures to see which is higher and why.

Dr. **Ditzler**. Another of the differences is regional costs. We are presenting an average cost on a nationwide basis. We have significant differences in some areas of our country.

Mr. **Molinari**. That can be broken down?

Dr. **Ditzler**. Yes, sir.

Mr. **Molinari**. Would you furnish that to the committee?

Dr. **Ditzler**. We would be happy to.

[Subsequently, the Veterans' Administration furnished the following information:]

The average per diem costs nationwide to the VA for 1984 for providing veteran nursing home care were:

VA Nursing Home Care Units (VA NHCU)	$107.84
State Veterans' Home Nursing Home (1st half year, $12.10; 2nd half, $17.05)	[1] 14.60
Community Nursing Home Care (CNHC) Facilities:	
Average Per Diem Paid	55.19
VA Support	3.19
	58.38

[1] The average per diem cost for 40 State Veterans' Home nursing homes in 28 states was $60.84.

Historically the average per diem cost nationwide of operating a VA NHC Unit has been higher than State homes or contracting for CNHC. One of the reasons is that the costs used to compute the average per diems have different bases. The VA nursing home care total cost is the summation of personnel and other costs incurred at those VA medical centers with nursing home care units. These costs have been distributed from organizational cost centers (i.e., medicine, radiology, etc.) to bed sections (i.e., medical, surgical, nursing home, etc.) based on estimates of usage of personnel time and other services rather than on the basis of individual patient charges for services received. The collocation of the VA nursing home with a hospital and the methodology for distributing all medical center costs may inflate the cost of VA nursing home care. Conversely, the community nursing home care cost is the summation of payments for care based upon negotiated rates for basic nursing home care services. These rates are operationally controlled so as not to exceed the legislative limitation. Because of these limitations the average per diem cost to the VA is most likely less than the national average per diem cost for all community nursing home facilities, and is slightly higher than Medicaid rates.

Another reason for the differences in per diem cost is that the services provided in VA facilities are not the same as those for which the VA contracts with community facilities to provide to a potential veteran placement. VA facilities provide a full range of services, without exclusion, to meet the varying needs of all veterans for nursing home care. Many patients need, and receive, much more intensive patient care services than the typical nursing home care patient. For instance, they require and receive specialized therapies and other services available at a medical center. On the other hand, VA contracts for basic nursing care services from community facilities for a negotiated rate. Community facilities generally will not provide a full range of services, such as occupational and physical therapy or expensive medications, to meet the needs of all veterans for nursing home care at a rate the VA is disposed to pay. Therefore, community nursing homes will not accept all patients that the VA proposes for placement at the contract rate, and usually exclude those requiring more than moderate patient care services. If more than routine services are required by a particular patient, such services are paid for separately or provided directly by the VA. The costs of such services are reflected in the community nursing home care per diem as part of VA support cost.

A third reason for the difference is that VA Nursing Home Care Units have a higher staffing cost than community nursing home care facilities. Cost of nursing services in VA Nursing Home Care Units is greater than the cost of nursing services in community nursing home care facilities due to a greater number of nursing care hours provided per patient per day and a higher proportion of licensed nursing personnel to nursing aides. Also adding to the higher staffing cost in the VA Nursing Home Care Units is the greater utilization of appropriately trained clinical dietitians, dietetic technicians, and food service workers.

The VA does not require community nursing homes under contract to provide a breakout of costs during rate negotiation. Because of this and the above reasons, there is no common basis for comparing the cost of VA nursing home care and community nursing home care contracted for by the VA.

The per diem costs of VA nursing home care units and community nursing home care facilities under contract with the VA vary from the nationwide average costs. The following list shows these costs (including VA support costs for CNHC) for each program by VA medical center grouped by region and medical district.

PER DIEM COST FISCAL YEAR 1984

	VA NHCU	CNHC
REGION 1—NORTHEASTERN		
Medical District 1:		
Bedford, MA	$85.68	$64.13
Boston, MA		61.40
Brockton, MA	89.30	65.87
Manchester, NH	99.24	64.96
Northampton, MA	93.74	64.94
Providence, RI		60.71
Togus, ME	110.89	62.96
White River Junction., VT	139.45	64.06
Medical District 2:		
Albany, NY	109.63	84.24
Batavia, NY	152.77	61.39
Bath, NY	53.95	75.26
Buffalo, NY	137.12	74.40
Canandaigua, NY	77.92	77.36
Syracuse, NY	112.24	71.87
Medical District 3:		
Bronx, NY		102.01
Brooklyn, NY	105.56	109.03
Castle Point, NY	105.01	89.83
Montrose, NY	93.82	93.82
Newington, CT		65.50
New York, NY		106.21
Northport, NY		92.84
San Juan, PR		15.38
West Haven, CT	89.74	95.01
REGION 2—MID-ATALNTIC		
Medical District 4:		
Coatesville, PA	94.99	58.02
East Orange, NJ	125.05	61.27
Lebanon, PA	84.79	59.89
Lyons, NJ	90.45	65.65
Philadelphia, PA		62.85
Wilkes-Barre, PA	95.49	64.62
Wilmington, DE	135.90	65.85
Medical District 5:		
Altoona, PA	123.45	63.80
Butler, PA	105.81	60.95
Clarksburg, WV		49.20
Erie, PA	112.73	68.31
Pittsburgh, PA (UD)	97.10	65.76
Pittsburgh, PA (HD)		58.58
Medical District 6:		
Baltimore, MD		63.33
Ft. Howard, MD	124.77	57.50
Martinsburg, WV	112.77	55.18
Perry Point, MD	122.64	58.35
Washington, DC		35.03
Medical District 7:		
Beckley, WV	98.71	50.14
Hampton, VA	101.62	63.61

PER DIEM COST FISCAL YEAR 1984—Continued

	VA NHCU	CNHC
Huntington, WV		50.11
Richmond, VA	194.96	61.58
Salem, VA	95.28	57.55
Medical District 8:		
Asheville, NC	94.46	61.45
Durham, NC		61.68
Fayetteville, NC	96.94	57.60
Mountain Home, TN	116.66	51.94
Salisbury, NC	70.56	61.51
REGION 3—SOUTHEASTERN		
Medical District 9:		
Atlanta, GA	284.23	56.67
Augusta, GA	104.24	44.98
Charleston, SC		60.79
Columbia, SC	100.79	58.34
Dublin, GA	99.72	51.12
Medical District 10:		
Biloxi, MS	135.58	49.41
Birmingham, AL		46.44
Jackson, MS	94.25	46.43
Montgomery, AL		49.09
Tuscaloosa, AL	98.62	48.39
Tuskegee, AL	82.98	49.83
Medical District 11:		
Lexington, KY	93.51	54.25
Louisville, KY		60.56
Memphis, TN	127.72	53.69
Murfreesboro, TN	123.02	58.41
Nashville, TN		60.14
Medical District 12:		
Bay Pines, FL	108.35	54.24
Gainesville, FL	111.00	56.92
Lake City, FL	124.94	51.60
Miami, FL	157.36	58.86
Tampa, FL		58.52
Medical District 19:		
Alexandria, LA	84.95	44.07
Fayetteville, AR		47.26
Little Rock, AR	91.07	49.70
New Orleans, LA		48.58
Shreveport, LA		44.19
REGION 4—GREAT LAKES		
Medical District 13:		
Chillicothe, OH	91.12	51.32
Cincinnati, OH	103.40	54.44
Cleveland, OH	108.72	59.47
Dayton, OH	91.93	54.21
Medical District 14:		
Allen Park, MI	123.70	64.91
Ann Arbor, MI	391.73	61.91
Battle Creek, MI	88.70	56.68
Saginaw, MI	143.48	60.73
Medical District 15:		
Danville, IL	89.74	55.53
Ft. Wayne, IN	97.92	61.83
Indianapolis, IN	126.51	61.60
Marion, IN	88.37	55.18
Medical District 16:		
Iron Mountain, MI	105.10	51.76
Madison, WI		61.40

PER DIEM COST FISCAL YEAR 1984—Continued

	VA NHCU	CNHC
Tomah, WI	75.33	55.41
Wood, WI	79.46	54.69
Medical District 17:		
Chicago, IL (LS)		66.58
Chicago, IL (WS)		63.15
Hines, IL	147.07	59.29
North Chicago, IL	83.05	57.43
Medical District 21:		
Columbia, MO	100.60	53.03
Marion, IL		57.63
Poplar Bluff, MO	109.55	54.30
St. Louis, MO	131.02	57.10
REGION 5—MID-WESTERN		
Medical District 18:		
Fargo, ND	89.11	57.15
Minneapolis, MN		70.86
St. Cloud, MN	99.62	61.48
Sioux Falls, SD	79.13	56.57
Medical District 20:		
Bonham, TX	80.97	38.26
Dallas, TX		45.57
Houston, TX	116.59	43.39
Kerrville, TX	146.23	41.98
Marlin, TX		37.74
Muskogee, OK		46.63
Oklahoma City, OK		55.03
San Antonio, TX		40.07
Temple, TX	82.39	39.11
Waco, TX	88.61	39.46
Medical District 22:		
Kansas City, MO		57.55
Leavenworth, KS	108.64	50.53
Topeka, KS	78.43	45.38
Wichita, KS	122.73	63.52
Medical District 23:		
Des Moines, IA		51.23
Ft. Meade, SD		50.32
Grand Island, NE	109.80	45.56
Hot Springs, SD		52.91
Iowa City, IA		56.49
Knoxville, IA	101.72	49.15
Lincoln, NE		58.80
Omaha, NE		57.47
Medical District 24:		
Cheyenne, WY	103.82	49.00
Denver, CO		55.06
Ft. Harrison, MT		62.07
Ft. Lyon, CO	112.31	53.42
Grand Junction, CO	112.31	45.59
Miles City, MT	119.14	47.07
Salt Lake City, UT		51.19
Sheridan, WY		55.38
REGION 6—WESTERN		
Medical District 25:		
Albuquerque, NM	131.14	58.79
Amarillo, TX		49.91
Big Spring, TX	112.33	47.72
Phoenix AZ	99.37	59.29
Prescott, AZ		59.11
Tucson, AZ	93.94	59.87

PER DIEM COST FISCAL YEAR 1984—Continued

	VA NHCU	CNHC
Medical District 26:		
Loma Linda, CA	148.47	59.54
Long Beach, CA	117.41	65.62
San Diego, CA	105.21	65.78
Sepulveda, CA	130.14	58.30
West Los Angeles, CA		61.86
Medical District 27:		
Fresno, CA		51.95
Honolulu, HI		89.71
Livermore, CA	150.95	65.25
Martinez, CA		65.83
Palo Alto, CA	93.20	65.68
Reno, NV	191.50	68.22
San Francisco, CA		77.25
Medical District 28:		
American Lake, WA	87.56	56.57
Anchorage, AK		154.64
Boise, ID		52.64
Portland, OR	179.09	62.67
Roseburg, OR	89.87	56.54
Seattle, WA		67.88
Spokane, WA		50.22
Walla Walla, WA		67.14

Source: Summary of Medical Programs, September 1984, Office of Information Management and Statistics, pgs. 77-79

Mr. MOLINARI. Thank you.

Thank you, Mr. Chairman. I have no further questions.

The CHAIRMAN. Thank you.

The Chair recognizes the able chairman of the Hospitals and Health Care Subcommittee, Bob Edgar.

Mr. EDGAR. Thank you, Mr. Chairman.

Mr. Chairman, I have about three rounds of questions, and I'll try to be as specific as I can. The questions I don't get to ask I would like to also submit for the record.

Mr. Walters, I wonder if we could turn your attention to the charts you provided dealing with average employment. You have a chart that lists the total number of people within the Agency in 1986 as 220,783. Is that your estimate of how many people will be employed?

Mr. WALTERS. Would you refer to the page, please?

Mr. EDGAR. There are no pages, unfortunately. It's just a chart that says down 919.

Mr. WALTERS. And the question was again, Mr Chairman? I'm sorry.

Mr. EDGAR. I am asking whether or not that figure is accurate, 220,783.

Mr. WALTERS. Yes, that figure is accurate.

Mr. EDGAR. Well, I am a bit confused, because we had some testimony with Dr. Ditzler, and we're looking at page 5-35 of this submission, which is Medical Programs—Fiscal Year 1986, Volume II. On that page, looking at employment analysis just in the health care area, the employment in health care is down from what our recommended level was by 1,273 people. On your chart it is only down 42 people.

Can you tell me how that is different?

Mr. **Walters**. I cannot, but I will for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

The chart below provides an analysis of the Department's employment estimates for 1985 and 1986.

Appropriation	1985		1986 request	Change (+ or −)
	Budget	Current estimate		
Medical care	193,321	191,849	192,048	+199
Medical research	4,595	4,505	4,348	157
Medical administration	876	837	753	−84
Canteen	3,530	3,530	3,530	
Total	202,322	200,721	200,679	−42

The 42 average employment (FTEE) reduction represents the change in 1986 from the current 1985 estimated employment level for all programs in the Department of Medicine and Surgery. The 1,273 FTEE reduction represents a comparison between the 1986 employment request (192,048 FTEE) and the 1985 request (193,321 FTEE) for the Medical Care appropriation. The following adjustments bridge the 1985 budget FTEE level with the 1986 request for the Medical Care appropriation. First, in 1985 appropriation action, Congress provided an additional 620 FTEE for various medical program initiatives. A common service employment adjustment of 9 FTEE more accurately reflects field support provided by the Department of Veterans Benefits. The absorption of nearly $106.7 million in supplemental pay benefits results in a 1950 FTEE reduction in 1985, which will not affect the 1985 budgeted workload levels, i.e. sufficient dollars and employment are available to meet the workload levels for which appropriations were made. The remaining net increase of 66 FTEE reflects the impact of the 1985 rescission resulting from the Deficit Reduction Act of 1984 (133 FTEE) and the 199 FTEE requested employment increase in 1986. This employment increase is discussed in Volume II of the 1986 Budget request.

Mr. **Edgar**. It is a concern of mine that the numbers that you use for 1985 of 221,702 people, those numbers that you're using there, whose numbers are they? Are they the VA's numbers or OMB's numbers?

Mr. **Walters**. I'm going to ask the Controller to help me on that, Mr. Edgar.

Mr. **Hoffman**. Mr. Edgar, I am Conrad Hoffman, the Controller.

Mr. **Edgar**. Could you come to the microphone, please?

Mr. **Hoffman**. The figures that you are looking at are figures that have been agreed to by OMB and the Veterans' Administration. The first question you had was comparing the original 1985 budgeted employment level with the 1986 request for the medical care appropriation. Your second question addresses the total employment for the agency.

Mr. **Edgar**. Well, that's my question. Because the Appropriations Committee gave you authorization to hire more people than you're hiring in the area of medical benefits by over a thousand. We can argue as to what that number is.

Mr. **Hoffman**. In that neighborhood, that's correct, sir.

Mr. **Edgar**. Are you planning to send up to the Congress a rescission or a change in your plan?

Mr. **Hoffman**. I will defer to Dr. Ditzler, but what is reflected in the 1985 column in the 1986 budget is a lower employment level, and it is related to the dollars that are available to support that level of employment. Basically, what Dr. Ditzler and his staff have done is try to accommodate a balanced program with the funds that were available in 1985.

Mr. EDGAR. I appreciate the careful work that the VA is doing in terms of these numbers. I guess my problem is that Congress authorized a certain level of staffing because we expanded programs, we set up readjustment counseling programs, we increased some of the responsibilities of our health care system, and someone is making a decision that those programs aren't going to be adequately or fully funded and, therefore, are making decisions in terms of reductions. When you say they are only minus 42 in the medical care, that is minus 42 below the loss of over a thousand jobs that someone made a decision to cut.

Mr. HOFFMAN. The minus 42 FTEE is for the total Department of Medicine and Surgery. Its the difference between the revised 1985 employment level and the 1986 employment level.

Mr. EDGAR. So in the medical care area alone, there are over a thousand less than Congress had intended.

Mr. HOFFMAN. One of the concerns that the Department had in developing their justification was the fact that the 1985 pay raise was only recognized at 50 percent and that provided a problem to the Department of Medicine and Surgery in meeting the approved 1985 FTEE level.

In other words, of the total pay raise requirement of about $179.2 million, the Department received about $72 million for pay in 1985. Therefore, they had to absorb the additional $107 million in 1985 operations.

Mr. EDGAR. Mr. Chairman, the staff has provided me with a fact sheet on the proposed 1986 budget which looks at the employee reductions. I would like to make that available to the members of this committee so that you understand fully the number of people that are reduced over the intention of Congress in the area of medical care and what the implications of that are.

I thank you for responding. I have additional questions, but I will yield to my colleagues.

The CHAIRMAN. Thank you.

The Chair recognizes Don Sundquist from Tennessee.

Mr. SUNDQUIST. Thank you, Mr. Chairman.

Mr. Administrator, you may have to give me this for the record, but in broad terms, the total savings based on changes in policy and recommendations in this budget, if they were not put in—including the nonconsolidation of regional facilities, not having a 5 percent user's fee, no reduction in employees, no means test, those kinds of things—how much more is the budget going to be if none of those things are approved. Please answer just in round numbers?

Mr. WALTERS. Well, I would have to supply all of it for the record, but clearly, the 5 percent user fee, even the adversaries of such a move would subscribe to the fact that 5 percent would raise at least $400 million. So the budget would be $400 million higher.

[Subsequently the Veterans' Administration furnished the following information:]

TOTAL SAVINGS

[Dollars in thousands]

	Fiscal year 1986—	
	Amount	FTEE
Consolidation/Modernization:		
DVB Regional Offices	$15,600	624
Less cost of regional consolidation	−25,100	
Data Processing Centers	2,900	113
Loan guaranty 5 percent funding fee	[1] 404,600	
Medical care—Means test[2]		
GS 11-15 reduction:		
Medical care	7,570	
Medical and prosthetic research	530	
MAMOE	250	
General operating expenses	2,045	
Subtotal	10,395	
5 percent pay reduction:		
Medical care	202,974	
Medical and prosthetic research	4,287	
MAMOE	1,240	
Construction, General Administration	1,007	
Department of Veterans' benefits	12,324	
Department of Memorial Affairs	1,093	
General operating expenses-staff	5,421	
Total, appropriated	228,346	
Third party reimbursements	65,000	
Medical care		
1 percent productivity	52,367	1,916
Supply savings	16,152	
10 percent Administrative reduction:		
MAMOE	5,155	85
Construction, General Administration	3,910	30
Department of Memorial Affairs: A-76 contracting, net savings	300	73
General operating expenses staff: productivity savings	1,700	58
Total VA savings	781,325	2,899

[1] Outlay savings of $604,600

[2] No budgetary effect in fiscal year 1986

Mr. SUNDQUIST. Maybe the Controller can give us just a round figure. How much of an increase are we talking about?

Mr. HOFFMAN. We're talking a little more than $400 million, sir.

Mr. SUNDQUIST. No, I'm talking about everything. Is that $400 million total for everything?

Mr. WALTERS. We would have to supply that for the record. It is more than $400 million. There's no question about that.

Mr. HOFFMAN. If you're talking about all programs, we're probably looking at perhaps double that figure.

Mr. SUNDQUIST. Double that figure.

Mr. HOFFMAN. Yes, sir.

Mr. SUNDQUIST. So we're looking at $800 million on a budget that is $27 billion.

Mr. HOFFMAN. Sir, were you also bringing in the 5-percent pay cut? If we're talking about that, that's another $238 million.

Mr. SUNDQUIST. I'm talking about everything. I would like to have it in simple terms, what it is going to mean if these proposals aren't approved.

The CHAIRMAN. Would the witness use the microphone. We would like to get answers if we could; "for the record" doesn't really help us. If you could come close to answering the questions. Putting it in the record just doesn't work.

Mr. SUNDQUIST. I don't believe your mike is on.

Mr. HOFFMAN. Your question again, sir?

Mr. SUNDQUIST. If the proposed reductions that you have in the budget that is going to be submitted were not approved by this committee, or by the Congress, how much are we talking about?

Mr. HOFFMAN. I would say on the order of $750 to $800 million.

Mr. SUNDQUIST. That's about what, 4 percent?

The CHAIRMAN. Counsel would like to comment on that.

Mr. FLEMING. It's closer, Mr. Sundquist, to about $1.2 billion.

Mr. SUNDQUIST. $1.2 billion? Mr. Walters, when can you give us those numbers—and I think time is a problem, because we're going to be moving along on the budget process. If we wait too long, the answers are not going to be of any value.

Second, Can you separate out what percentage of the proposed savings are changes that would come from internal savings, or efficiency changes, regional centralization and those kinds of things, as opposed to those changes that could be construed as broken commitments or even bruised commitments that have been made, or people feel like they've been made, I would like to separate those figures out that way, Mr. Chairman, efficiency kinds of savings as opposed to changing policy that will have impact on the veteran.

Other than needing that information, that's all the questions I have, Mr. Chairman.

The CHAIRMAN. The Chair said earlier that he has instructed his staff—and Mr. Hammerschmidt has also done the same thing—if we can find savings in certain areas, we certainly will bring those savings forward to the Budget Committee, which we have done in the past. In fact, we have cooperated and have gotten our savings in quicker than other committees. It was over $1 billion over a 4-year period, as I said before.

I would like to see some of these other committees do something and play ball with the budget process. We have always been right up front and I want some other committees to start showing the same dedication that we have.

The Chair would like to recognize the gentleman from Illinois, Mr. Lane Evans. Also, I would like to thank him for holding the hearing in Miami pertaining to the Vietnam veterans and the Emergency Jobs Training Program, to see how that program is working. Thank you for going down there.

Mr. EVANS. Thank you, Mr. Chairman.

I would like to just follow up on what Mr. Sundquist asked in regard to the savings. Earlier Mr. Hammerschmidt asked if we knew the resource requirements for implementing the means test, and I would additionally ask if we know the staffing and funding requirements for the third party reimbursement. If we don't know those costs, those have to be offset with any savings that might be figured in.

Do you have any figures for, first of all, the third-party reimbursement staffing requirements, and have those been factored in, those costs as well as the costs of implementing the means test, been factored into these savings that we're supposed to receive?

Mr. WALTERS. No; they have not been factored in. Miss Quandt is our expert in this area and perhaps can be more helpful.

Mr. EVANS. All right.

Ms. QUANDT. Mr. Chairman, we have not completely finished our analysis of the proposed legislation, on either the means test or third-party payment. However, an agreement has been made between the agency and the Office of Management and Budget that for any savings achieved through productivity improvements, either because of contracting out or management efficiency studies, those ceiling positions will be left with the Department and that will serve as the funding base and the staff base to carry out these new initiatives.

Mr. EVANS. Mr. Walters, how many veterans do you estimate are presently eligible for veterans health care benefits and how does that number compare with estimates of a year ago?

Mr. WALTERS. I don't know if I can answer that question right off the top of my head.

Dr. Ditzler, do you have anything to add?

Dr. DITZLER. The question of eligibility is essentially driven by the total number of living veterans, because there are graduated priorities of care. So if you're talking about those who are service-connected versus nonservice-connected, there are still levels of gradations of care. Essentially it is the number of living veterans.

The CHAIRMAN. Doctor, I'm sorry. We're not hearing at all up here. We are not hearing the witness over there and we're not hearing you.

Dr. DITZLER. I need more specificity in the question.

Mr. EVANS. The information we have is that basically there are three categories of veterans: People with service-connected conditions, those receiving VA pensions, and those either over age 65 or people who need health care because they can't offset the costs. That estimate we have this year of total eligible veterans is 12,113,000. I don't have it for last year. I would assume that it's probably up.

Dr. DITZLER. It's approximately the same—about 12.5 million.

Mr. EVANS. But, in addition, while there may be in the future fewer newer veterans being added, it is true, isn't it, that that population will age and that the numbers of elderly veterans will increase, as well as the number of veterans who, when they reach those ages, tend to have their income go down because of the declining purchasing power that they have, not working in retirement and so forth? Isn't that correct?

I guess what I'm going after is that the 1979 survey sponsored by the VA found that only 5-percent who relied entirely on the VA for their hospital care had incomes of more than $15,000. So I guess I would see a likely increase in the number of those veterans eligible for health care, particularly the older veterans. And even assuming the enactment of legislation reducing the number of eligible veterans, the total number of veterans seeking health care from the VA is likely to increase, particularly as they get older and, as the VA has said, the number of patients will probably increase because older persons consume relatively more health services than younger ones and they tend to be more indigent than the younger veterans.

So, since this budget assumes no significant increase in the number of patients treated, what kind of provisions is our Government going to make to provide health care for those veterans unable to obtain it from the VA?

Dr. **Ditzler**. You have raised a series of questions. The 1986 budget does not presume to answer all the questions concerning the aging veteran. The aging budget is one that we will have to present to the Congress. Studies on aging are ongoing. It is still subject to concerns, pro and con. I don't think it was our intention to fully resolve the issue of the aging in the 1986 budget. That is something yet to be presented.

Mr. **Evans**. My time has run out and I would like to submit some further questions.

How many veterans over the age of 65 would lose their eligibility if this legislation enacting this means test was enacted?

Dr. **Ditzler**. I don't know sir.

Mr. **Evans**. Well, we need those kinds of figures, and I would appreciate it if you would follow up——

Mr. **Walters**. I think if the law allowed that we treat them the same as veterans under age 65, there would be some veterans who would lose their eligibility. Whether they use the system or not is a matter of conjecture and speculation. We don't know for sure. We assume some will. Most veterans with incomes over $15 or $20,000 a year do not use the system now. We know that. Whether they will in the years to come, we don't know the answer to that, Mr. Evans. It's a good question and one which we should always strive to answer.

Mr. **Evans**. I hope you do some thinking along those lines. I hope these costs of transferring whatever people may lose in their eligibility in the VA system to other Government programs were factored in in terms of the overall savings to the deficit that you're projecting. It doesn't make a lot of sense to me to simply say we're saving money in the VA when people may be pushed into other health care systems.

Mr. **Walters**. I can't agree more with you. I think that's part of the debate on the policy issues of the outyears that we have to resolve collectively so we do not give our veterans false expectations, but tell them what it is they are going to receive and then give it to them. I'm not so sure we're there right now.

Mr. **Evans**. Thank you. I appreciate it.

Thank you, Mr. Chairman.

The **Chairman**. Thank you, Lane.

Before recognizing Dr. Rowland, I would like the record to show, if you can give us these figures—Aren't most of the veterans treated in the veterans hospitals below the income of $15,000, that is in the lower income?

Mr. **Walters**. Yes, sir; that is correct.

The **Chairman**. We're taking care of those other lower incomes and not the high income, the real high income; and in compensation also, isn't that correct?

Mr. WALTERS. I can't speak to the compensation part of it. Their compensation could put them in an income category which would put them above indigent. Service-connected veterans would not be subjected to the means test anyway. But the fact of the matter is that most veterans who come to the hospital are not well-to-do, whether they are service-connected or non-service-connected.

The CHAIRMAN. I would like to recognize Dr. Roy Rowland of Georgia and thank him for the help he has done on this committee and the interest he has shown on the committee.

Dr. Rowland.

Dr. ROY ROWLAND. Thank you very much, Mr. Chairman, and thank you, Mr. Walters, for being here this morning.

Mr. Chairman, I will have some additional questions to submit for the record. But I would like to know what idea do you have insofar as a slowing down of renovation of hospital and health care facilities that might be taking place under the budget constraints that we have now.

Mr. WALTERS. Well, in the 1986 budget, we have very little slowing down, since we have a $160 million roll over from recent appropriations. So our total expenditures will be approximately the same as they were in 1985 for construction.

Dr. ROY ROWLAND. I was thinking more about renovation that is taking place now. I understand there might be some slowdown in renovation.

Mr. WALTERS. We are not ready to say that at all. The outyear estimates for 1987–90 of this budget are plugged numbers in the area of construction. There are those who would like us not to build any more nursing homes and just convert the acute care beds over the years to nursing home care beds, and that's all. There are also those who would subscribe to doing much more than that. I think this policy has to be developed this year for the formulation of the 1987 budget, which will begin to reflect some real cogent thought about how we care for the aging veteran population that is coming to us.

It is not reflected in this year's budget. It simply isn't there.

Dr. ROY ROWLAND. I am certainly pleased to know that because I heard some concern expressed that there might be a slowdown in that area. I am pleased to know there is not going to be a slowdown.

Thank you very much, Mr. Walters.

Mr. EDGAR. Would the gentleman yield at that point?

Dr. ROY ROWLAND. Yes, I will.

Mr. EDGAR. Mr. Walters, in your response, that there is not going to be a slowdown, isn't it true that we had intended, in terms of new construction, to start construction on five facilities in 1986 and we're down to 2½.

Mr. WALTERS. Well, I can't speak to the entire spectrum of new starts. The fact of the matter is that we were constrained in the 1986, budget as were all agencies.

Frankly, in the area of construction, I think I have little room for complaint. You know, I had good negotiations in the area of the budget for construction in 1986. My major concern, frankly, is what's going to happen in the outyears, and I share that with Dr. Rowland.

Mr. **Edgar**. I just point out to the Committee that in February of 1981, the General Accounting Office said the following:

> The Veterans' Administration facilities are becoming functionally obsolete. Many of its hospitals are structurally sound but do not have enough room for the correct space configurations to accommodate modern medical equipment, outpatient facilities, or air conditioning and ductwork. Currently, about one-third of the VA's 172 hospitals have no air conditioning in the patient quarters. Although the agency is taking a hard look at its medical facilities, it is not replacing or renovating them fast enough to upgrade them to the new, higher standards for hospital occupancy.

I think Dr. Rowland is right in focusing on the question of renovation, because some of the construction projects are replacements and renovations of existing facilities that are very vital in order to provide quality of health care. And having plugged numbers for 1986, 1987, and 1988 really doesn't give us much comfort, given the $200 billion of deficit this year and the projected deficits in future years. Some of us are very nervous about whether or not we will, in fact, replace and renovate the existing facilities, let alone any new starts, in a sufficiently timely fashion to make the quality of care very high.

I thank the gentleman for yielding.

Mr. **Walters**. If I might just add a comment to that, not as an adversary to your statement, but I think the last three budgets, the three budgets which I have been involved with at the VA, were the largest construction budgets in the VA's history. The one that we present to you today is also very large, the third largest construction budget. I have a feeling that my opening statement is probably correct, and let me read that again.

"In that regard, no budget can adequately repay our veterans for all they have done for America," and I suspect that's probably true. We are not going to be able to supply all the money, all the resources necessary to do all we would like to do. I know the chairman shares this with me. We deal with finite resources and we're going to have to make some tough decisions. Of course, we are in the process of doing that now.

Mr. **Edgar**. If the gentleman would yield further, the fact that we have done very well over the last 3 years doesn't adequately address the fact that in over 20 years we may have deferred maintenance on these existing facilities and may not have kept up the pace. So that when you see the gigantic increases that we have made over years that look gigantic on the surface, in terms of the capital investment that we have put in place, we're just beginning to address these needs.

Our hearings on the 5-year assessment indicate that we have to keep at this level over the next couple of years in order to make up for the lost time in the sixties and seventies where we didn't adequately address rehabilitation. So I commend the gentleman for his high numbers. They may, in fact, be more in line with what we should have been doing in the past, given the capital and its deterioration.

Mr. **Walters**. Mr. Chairman, as the devil's advocate, let me point out to you that when I first came to the VA I thought VA hospitals could not chew bubble gum and walk at the same time. That's the American public's perception of a VA hospital care system. In fact, I find this hospital care system to be dynamic, growing, sensitive, compassionate, and very good. When I go out to visit military hospitals, I see the difference between what it means to properly care for a hospital and one which is not properly cared for. The VA does a much better job than the military—and all my friends in the military will now come to haunt me—in caring for veterans, and we have better construction and better facilities.

You know, I just think we have to set the record straight about what we have out there in the VA medical care system. It's a marvelous system, it's a good one, and I think the criticism we get is not always justified. So I don't know where the report came from. I haven't seen that report. But the fact of the matter is, most of the hospitals I go to, I am pretty doggoned proud of.

Dr. **Roy Rowland**. Mr. Chairman, if I can reclaim my time, which is now gone—[Laughter.]

The **Chairman**. You've been around here long enough not to yield your time. I'm surprised. [Laughter.]

Dr. **Roy Rowland**. Mr. Chairman, this is my second term and I'm learning fast.

I thank the Chairman of the Hospitals and Health Care Subcommittee for his comments on that, and also Mr. Walters. May I say parenthetically here that I am very pleased to have the opportunity to serve on this committee again this term. I will now relinquish whatever time I might have back to the Chair.

The **Chairman**. Thank you. And you have no choice. We are going to make you serve on the committee.

Mr. Walters, I like the positive statement you gave. That shows the old Army fight you have. Stand up and kick them, and when they kick us, kick back.

Mr. **Walters**. It's the Army mule in me.

The **Chairman**. The Chair recognizes a new member of the committee, another Rowland, John Rowland of Connecticut. He's not one of our older members. In fact, he's the youngest Member of Congress.

The Chair recognizes the gentleman.

Mr. **John Rowland**. Thank you very much, Mr. Chairman.

Let me point out that I, too, share your feelings about the means test and the increase in the user fee and the consolidation of the regional offices.

Mr. Walters, I think Mr. Stockman would be pleased to hear that you're taking on the military, also, and take some heat off of him.

In 1985 the user fee, I believe, was raised from ½ percent to 1 percent. In your opinion, what effect would the 5-percent user fee have on the price of a loan? I understand from some of the estimates we have, it would be about $3,000. Is that in the ballpark?

Mr. **Walters**. That's in the ballpark, yes, sir.

Mr. **John Rowland**. Is the 5-percent user fee for the GI loans duplicated by a similar proposal at FHA or the Farmers Home Administration?

Mr. **Walters**. It's a governmentwide policy.

Mr. **John Rowland**. So it is duplicated. OK.

Mr. **Walters**. I want to make sure I understand the question. It is a governmentwide policy in that FHA will be required, under the legislation proposed this year, to impose a 5-percent user fee, as will FmHA and the VA. When you say duplicated, I'm not so sure I understood the question.

Mr. JOHN ROWLAND. Duplicated by a similar proposal, I should say. The proposal is duplicative.

Mr. WALTERS. It will apply to various government loan guaranty programs—Yes.

Mr. JOHN ROWLAND. On another subject, there has been some talk about other savings. Some time ago the VA accepted telephone calls for changes in dependency, such as births and marriages, the same for changes of address. A GAO report some time ago caused you to change your procedures.

In your opinion, are the new procedures more costly or less costly?

Mr. WALTERS. I'm going to ask Mr. Hagan, our Chief Benefits Director, Mr. Rowland, to answer that question.

Mr. HAGAN. Thank you, Mr. Chairman.

I don't think that these procedures are any more costly than the prior procedures. For years we had been requiring people to submit evidence of marriage, and then we did get away from that. The procedures that we have now, it is only a matter of requesting one additional document. The document comes in and is processed along with the application. So there is no impact on us.

Mr. JOHN ROWLAND. So it is safe to say that it hasn't cost you any more but it certainly hasn't saved you any money, either?

Mr. HAGAN. No, it has not saved any—Well, when I say not saved any money, the basic issue was one of falsification of documents, reporting dependencies that did not exist. Whether or not we can project and say that that has saved the cost of fraudulent claims, I do not know.

Mr. JOHN ROWLAND. So you would say that the procedure was better as far as having accurate information, but it didn't necessarily save money?

Mr. HAGAN. I would say that is so.

Mr. JOHN ROWLAND. OK. Thank you very much.

I yield back the rest of my time to stay in good graces with the committee. Thank you, Mr. Chairman.

The CHAIRMAN. You certainly are learning. [Laughter.]

The Chair would like to recognize the gentleman from Pennsylvania, Mr. Kanjorski.

Mr. KANJORSKI. Thank you very much, Mr. Chairman.

Mr. Walters, I am interested in something that you discussed, the modernization program and consolidation program. I have a district that is far removed from central offices like Philadelphia. The reports that I'm getting back are that as the veteran gets elderly, he is unable to respond to questions on the telephone and get adequate answers. It seems that the Veterans' Administration in our particular area of Pennsylvania is getting a reputation similar to the IRS. I think we all appreciate how frustrating it is to have a busy telephone line that never gets answered and someone on the other side who has an anonymous voice and no identification.

I was wondering, are you paying close attention to the quality of service and taking into consideration the lower educational level and the infirmities of age that the veteran is going through when he is requesting information, to improve the quality as well as the quantity of service?

Mr. WALTERS. One of the principles of our modernization goal is to make sure that anything that is done is done with the veteran as the building block. In other words, we're not going to try to make the computer user happy just to make a computer user happy; we're going to make the computer user happy because he is able to deliver that veteran's benefit quickly, more efficiently, and if necessary, more personally.

But what we have now is a lag time between the amount of information available to people on the phone to that veteran, because we work from paper files and we have 30,000 square feet in every regional office devoted to just the warehousing of paper files. We are where Sears and Roebuck was 20 years ago in terms of the dissemination of information. If you lived in Miami and went to the Sears store in San Francisco 25 years ago, you might have trouble getting your credit card approved out there, because they weren't disseminating that information very well. Now they are. We are not.

That is what I'm really talking about in the area of modernization. Any time we talk about quality of service to veterans, we should be doing that all the time. In terms of personal service, we should always be there.

Mr. KANJORSKI. Can I assume from your answer that there are no extended plans to close some of these outreach or regional offices?

Mr. WALTERS. None that I know of. I'm not saying that somebody, somewhere, hasn't got it in the back of his head. But it's not in mine.

Mr. KANJORSKI. Mr. Walters, what would you suggest to a young Member of Congress who has the experience of having material that indicates those outreach offices are intended to be closed by some internal studies with the Veterans' Administration? Should I take that up directly with you or your staff, sir?

Mr. WALTERS. Of course, absolutely.

Mr. KANJORSKI. Thank you very much.

Mr. WALTERS. We welcome your input.

Mr. KANJORSKI. I yield back the balance of my time, Mr. Chairman.

The CHAIRMAN. Thank you, sir.

The Chair would like the record to show that Mr. Tim Penny of Minnesota was here and he had to leave. I wanted the record to show that.

The Chair recognizes the gentleman from Florida, Mike Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

I, too, sir, would like to offer my kind commendation, if you will, to Mr. Walters for the great job that he is doing. I have been with him out in the field, and have seen him mix with the veterans on a grassroots basis. He is very well received. Basically, sir, you're considered a champion by the veterans in my area and I commend you for that. You did not have a tough act to follow, it was certainly one which was not well received by the grassroots veteran. But you changed all that.

Very quickly, I have a question in a very sensitive area—although my common sense and logic, which I am finding out very quickly is not always applicable up here, would seem to indicate to me that it should not be so sensitive—is in the area of third party reimbursements. I understand legislation was introduced a number of years ago and the veterans groups opposed it to a very large degree and it didn't go anywhere. That is small wonder, with that type of opposition.

Basically, hasn't it been the case that private insurers have been benefiting by virtue of the fact that they have not been required to reimburse the VA for these medical services?

Mr. **Walters**. I don't want to speak for the private insurers. They may perhaps be better off speaking for themselves. I will say this—the VA has billed private insurers over the years and has received payment, even though their policy may say they shouldn't pay. Now, that was interesting to me. It was new information for me just this year as we looked at third party reimbursements. Unbeknownst to them, or at least they seemed to be somewhat surprised by it, they are, indeed, paying the VA money for care.

Mr. **Bilirakis**. And they have been for some time?

Mr. **Walters**. Yes, sir.

Mr. **Bilirakis**. Is it then VA policy to bill private insurers and this has been done on a 100-percent basis?

Mr. **Walters**. Yes, it is.

Now, Miss Quandt is our expert-in-residence this morning on that issue. If you wish, she would be happy to address that further for you.

Mr. **Bilirakis**. All right. I hate to take too much time, Mr. Chairman, but I can't imagine the problem with this subject.

Go ahead, madame.

Ms. **Quandt**. The Agency has the authority to bill and collect for no-fault insurance, workmen's compensation, and victims of crime. We also have authority—and it has existed for well over 10 years—to bill for non-service-connected care, for those who, by right of their employment or membership in a union, carry health care insurance. We do bill for that. There are some companies which have disclaimers in their policies, but their clerks, not recognizing that, have paid and the Government has collected.

Mr. **Bilirakis**. May I ask you, madame, how about service-connected care? Have we billed in those instances?

Ms. **Quandt**. There may have been some instances. There is no given policy to collect insurance for such care.

Mr. **Edgar**. Would the gentleman yield for a quick question?

Mr. **Bilirakis**. Yes.

Mr. **Edgar**. Do you bill for Medicare?

Ms. **Quandt**. We do not bill Medicare.

Mr. **Edgar**. Why not?

Mr. **Bilirakis**. That was going to be my next question.

Ms. **Quandt**. Medicare has an exclusionary clause which states it will not pay for care given in Federal facilities.

Mr. **Edgar**. So do most of the insurance companies.

Ms. **Quandt**. Right. But some of the clerks in insurance companies have forgotten that and will pay our bills.

Mr. Bilirakis. Well, that was going to be the second part of my question, as far as this area is concerned.

Has the VA looked into what the Medicare reimbursement would be if, in fact, you were to bill Medicare, and get reimbursement from it?

Mr. Walters. Yes, I believe we have. Dr. Ditzler, what was the bottom line on that?

Dr. Ditzler. It would be a tradeoff from one Government agency to another.

Mr. Bilirakis. I appreciate that, except Medicare again is supposedly a separate trust fund, et cetera. But still, our concern as far as this committee is concerned is the veterans.

Dr. Ditzler. Essentially, Medicare pays only for inpatient care, so we're talking a maximum of 40 percent of the total VA health care budget. Many of the issues of billing would not fall into the areas that we call pass-throughs, such as special money for spinal cord injury, special money for blind rehabilitation centers. In that arena there is no comparable base for billing Medicare. At most, if we would bill for every single veteran over the age of 65, it would only be the inpatient arena that would produce significant cost recovery.

Mr. Bilirakis. Is the committee to go into this subject of third-party reimbursement, Mr. Chairman?

The Chairman. I think it's an excellent idea. We had better go into it. We will continue in this area and——

Mr. Bilirakis. All right. I will defer any further thought on that. The red light is on in any case. Hopefully the committee can get into it. I thank you, sir.

The Chairman. Thank you. We certainly will get into it.

Mr. Staggers of West Virginia.

Mr. Staggers. Thank you, Mr. Chairman.

Thank you, Mr. Walters. I appreciate you coming and I compliment the work you have done while I have been a member of the committee. I would agree with the quote that you used; I wouldn't want to be in your position, either. I can appreciate the difficulty that you have.

One comment that I would like to direct, though. It appears, as we discuss several of the budgetary items, the argument can be focused on two sides. We can look at the cost—and I think all of us are now looking at the problems which we have with the budget—and you can look at the needs. I think the argument can be made that, because of the budgetary problems we have, we could do away with all the services we provide to the veterans. At the same time we could look at the needs the veterans should have and double the deficit problem, which we do have. I would hope we could find a middle ground and start looking at the needs that veterans do deserve. I know those are the goals that you share and I hope we can work together on those.

I do have some questions and some comments also. I share Mr. Edgar's concern and I think, from what his questions were, concerning the decrease in employment, that this might adversely affect some services which, in fact, we are providing to the veterans. I share those concerns and might submit some questions later for the record.

One of the things which sort of upset me was the means test, which you said you don't have but is on your desk. I would like to see that. My question would be, your statements today have been that we're not taking care of middle-class, affluent Americans. When you have this means test, are you going to reflect those facts into the means test, or are we going to revert and maybe cut some of the people out that we are in fact servicing today? Can you give us an idea of what this means——

Mr. WALTERS. We would hope to do that in the fiscal year 1986 or 1987 budget. A survey will give us more definitive information.

I don't know if you were here, but we are developing a brief scenario, a survey, to determine how many people we're serving now. We will make that information available as soon as we have it.

Mr. STAGGERS. What I'm saying is, the problem right now is not that we're servicing the affluent veteran; he is not making use of the system anyway. We're talking about using a means test for nonservice-connected veterans. Are you going to take that into consideration when this means test comes into play? Are you going to have it high enough so that we're going to be able to service the people we're servicing now?

Mr. WALTERS. I think so. We will also have a grandfather clause for those who are in an episode of care now. This will be a feature of the means test.

Mr. STAGGERS. Another question I had, which I think Mr. Rowland touched on, about the aging veteran and converting the acute care to nursing home type care. I know in Martinsburg, in my district, we are switching over to a new hospital, which I am very grateful for and the veterans of my district are grateful for. But we are tearing down the old hospital.

Has there been any type of analysis of what it would cost to actually tear down the existing structures and what it would cost to convert those to a nursing home type of care?

Mr. WALTERS. The VA does a lot of that work.

Mr. STAGGERS. Can you speak to that particular incidence?

Mr. WALTERS. I can't speak to that specifically. We will have to find out and supply that information for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

We have not made an analysis of the cost to convert the existing structures of the old hospital to nursing home type care. The old hospital buildings were constructed in 1943 by the Army as temporary structures, and they are not considered suitable in structure, space or configuration for conversion to meet current standards for nursing home care. A number of old hospital buildings were initially removed to provide space for the construction of the replacement facility. The final phase of the replacement medical center project will demolish 29 buildings at a cost of $854,000. This cost includes removing asbestos from the buildings, removing PCG transformers, carting away the building debris, grading the site and landscaping the area.

Mr. STAGGERS. I appreciate that.

I just recently talked to some Vietnam veterans in my district and there is very little outreach type of services available. I do know that Martinsburg provides some. The Vietnam veterans are not using that because they run into some obstacles. There are some contract services I know out of Hagerstown, MD and Cumberland, MD, that service a large portion of my district. I understand there are going to be some cuts in those services, also, which will pretty much eliminate a lot of those services to the Vietnam era veteran in my district. Since the only real outreach program we have is in Morgantown, some for the Martinsburg VA center.

Have there been any studies to see about how that is going to directly affect the Vietnam veteran?

Mr. **Walters**. I'm sure there have, and that has been an ongoing concern of the VA as we expanded the Vet Center Program and contracted for the contract service. We reduced the contract services, but we tried hard to make sure the demographics were noted. I would be happy to supply that to you on an individual basis for the veterans in your district.

[Subsequently, the Veterans' Administration furnished the following information:]

The Veterans' Administration has readjustment counseling centers (Vet Centers) located in Huntington and Morgantown, West Virginia. We also plan to open a 2-person satellite for Vietnam era veterans in Martinsburg and a 1-person satellite in Charleston later this year. In addition to these VA facilities, the Agency has contracted with twelve private clinics to provide readjustment counseling services to eligible Vietnam era veterans who are experiencing social/psychological problems associated with their military service. Generally, Vietnam era veterans who live 50 miles or more from the nearest Vet Center or VA Medical Center, and request readjustment counseling services, are referred to private counselors. It is not the Agency's intention to stop providing fee/contract services to Vietnam veterans; rather, our goal is to provide these services in the most appropriate manner, either from VA, private contract providers or a combination.

When the new satellite in Martinsburg is operational, our counselors will conduct regular outreach to locate and assist Vietnam veterans residing in your congressional district. Our Morgantown Vet Center will also continue to outreach veterans residing in the northwestern part of the State of West Virginia.

Mr. **Staggers**. I notice my time is up, Mr. Chairman. There are some other questions. I hope my colleague from West Virginia will address the Clarksburg situation—whether the contraction is going to continue. I may have some additional questions I would like to submit at a later time.

Mr. **Edgar** [presiding]. Thank you. I would just remind everyone that if you have additional questions, we'll have another round so that you will be able to ask those.

Mr. Smith from New Jersey.

Mr. **Smith** of New Jersey. Thank you, Mr. Chairman.

First of all, Mr. Administrator, I would like to welcome you to this committee. I am delighted with your leadership of the VA as well as your very crisp answers today.

I do appreciate the genuine interest that you are showing in moving forward with a satellite outpatient clinic in south Jersey. The record clearly indicates that it's needed and we appreciate your help on that. We are moving ahead on that in a very bipartisan way. My colleague, Mr. Florio, and I are pushing forward and I thank you for your help.

Mr. Administrator, many of us believe that the proposed 5-percent user fee on the VA Home Loan Guarantee Program will severely damage the program. I was encouraged a few weeks ago to read in an Associated Press article that you indicated, you personally, privately, opposed the 5-percent user fee and did not intend to really push its adoption. I wonder if you could elaborate on that for the committee.

Mr. **Walters**. Well, I was somewhat misquoted in that article. The arrangement is that that is an across-the-board policy, across the Government, and for all home loan programs. That would include FHA, FmHA, and the VA. I can't speak for FHA and I can't speak for FmHA, and I don't want to. I have enough trouble just speaking for the VA.

Now, in terms of my concerns, let me clearly say that the 5-percent user fee is going to cure the financial problem, because 5 percent will, indeed, collect $400 million or thereabouts, which we are asking for. That will take care of the financial problem. But my concern is—and I think it's a legitimate concern, one which the Congress and anyone who is interested in it ought to be concerned about as well—what is the impact going to be on the home loan program? For something that's apple pie and motherland in America since World War II, it seems to me we ought to be very careful, very cautious, about what impact that will have on the veteran being able to start his new life. Since I just delivered the 11 millionth VA home loan a year ago, I feel sort of akin to this program. I don't want to throw the "baby out with the bath water." We have a range of opinions from the mortgage bankers, who say they won't make one more loan if we do this, to my own people, who say the program might be reduced as high as 50 percent—although we have some people who say it may be less than that inside the VA—to people who say it won't have any impact at all. I don't know the answer to that. I just subscribe to the fact that there is a possibility here that an old time, very effective veterans benefit might be in danger. That, to me, is something we ought to be careful about.

Mr. **Smith** of New Jersey. Being cognizant of that, wouldn't it be advisable, before we go ahead with imposing such a user fee, to have an authoritative study that would indicate what the impact would be on the veteran?

Mr. **Walters**. Well, I don't think we can do that. I think what we're doing now, we're projecting the future based upon no authoritative study. I think we're doing it on the basis that we need the income to fund the program. We are at the point where those who want the 5 percent user fees say it won't have any effect on the program. Those who don't want it, say it will kill it. It's somewhere in between. I don't think there's any infinite wisdom there.

All I am suggesting is if we adopt the 5-percent user fee, and there is some reason to believe the Congress may do that—and I have nothing against $400 million coming back into the pot, by the way—we ought to be watching very carefully to make sure that the program hasn't disappeared as a veteran benefit, because it's been a good one, just like the GI bill.

Mr. **Smith** of New Jersey. I think that's the concern that members of this committee have—the possibility of its disappearance, or its lack of use. You mentioned the mortgage bankers say their will not make one more additional loan. That's our concern.

Do you anticipate, if the Congress does not pass that legislation, that you will be coming forward and requesting a supplemental, and if so, how much for fiscal year 1986?

Mr. **Walters**. We estimate $406 million, which is the amount of money required to fund it, but I might add, I think we are somewhat derelict ourselves—and I say that tongue in cheek because

Bob O'Toole, who runs that program for us, in our Benefits Department, is an amazingly knowledgable guy. The fact of the matter is that I think we need to take a good look at how we appraise homes, and we're looking at that. I have asked the Inspector General to look at the appraisal situation, just look at it across the board, to make sure we are not appraising homes at higher values than we're actually foreclosing them for and being able to sell them for.

We are going to look at the time variable, between the time a veteran gets in trouble and the time we foreclose. Sometimes it runs as much as 2 years. That's a very costly matter. So we're going to look at that in terms of management, trying to get as sleek and as efficient a program as we possibly can, so that we don't have to ask for more funds than, indeed, we actually need.

Mr. SMITH of New Jersey. I have one final question now, Mr. Chairman.

It has been widely rumored that the administration was going to ask for a tax on compensation. No such request has been made today, at least as far as I can understand. In your opinion, is that proposal dead?

Mr. WALTERS. Well, I am not in the tax simplification business, so I don't know. I have directed a letter to Secretary Regan indicating he should take a real close look at the fact that we would tax a benefit. That's a benefit. That is reducing the benefit. I think that he was going to look at it—then Secretary Regan. Now it's Secretary Baker. I am sure they are going to look at it. It's a very serious matter, one that I understand this committee has taken an interest in.

Mr. SMITH of New Jersey. I would appreciate it if that letter could be made part of the record here, because I think that could help us in fighting the taxation proposal on compensation and on benefits.

Thank you.

[The letter follows:]

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS,
Washington, DC, December 28, 1984.

Hon. DONALD T. REGAN,
Secretary of the Treasury,
Department of the Treasury,
Washington, DC.

DEAR DON: I recently learned that the tax reform plan presented to the President by the Department of the Treasury contains a proposal to subject veterans' disability compensation benefits to taxation as income. I am writing to call to your attention several implications of this proposal of which you may not be fully aware.

Veteran's disability compensation is provided only for disability or disease incurred in the line of duty in the active military service of the United States. Our disability compensation program seeks to reimburse the disabled veteran for a specific loss, e.g., loss of a limb, loss of vision, associated with the veterans' service to this Country. Taxation of disability compensation benefits would take back from the veteran a portion of the compensation provided by law for this actual loss.

You should also be aware that additional disability compensation is frequently provided to a disabled veteran in need of regular aid and attendance to enable the veteran to obtain vital personal health care services on a daily basis. Funds for this purpose are intended solely to cover the cost of such services. A similar situation exists with regard to a veteran permanently housebound as a result of service-connected disability. Additional compensation is provided to cover the increased expenses associated with the veterans' restricted lifestyle. Any taxation of these benefits would thus diminish funds made available to the veteran to obtain necessary services. For example, a single veteran who is receiving disability compensation for service-connected loss of three extremities and who is in need of the aid and attendance of another person because of those disabilities, would suffer an effective loss of about 24 percent of his compensation at current tax rates.

The reaction of veterans to this proposal will almost certainly be one of shock and indignation. Representatives of major veterans' organizations have already spoken out against the proposal, and the numerous large and well-organized veteran's groups can be expected to uniformly condemn the proposal. The proposal is also likely to antagonize key members of the Senate and House Veterans' Affairs Committees. The support of these members will be crucial to Congressional action on a variety of deficit reduction measures now being contemplated by the Administration.

In my view, taxation of veterans' disability compensation benefits would be unjust in that it would violate our nation's longstanding commitment to provide for those who come to its defense in time of need. In our need to simplify the tax system seeking reforms which place taxing veterans compensation along with eliminating deductions for second mortgages does not seem very fair.

In view of the foregoing considerations, I urge you to reconsider the advisability of even proposing taxation of veterans' disability compensation benefits. I am personally in support of a tax simplification plan and those areas where no tax is paid should be examined. Scrutiny of that examination will hopefully show that taxing veterans compensation benefits is not appropriate. I would be pleased to discuss this important issue with you.

Sincerely,

HARRY N. WALTERS, *Administrator.*

Mr. EDGAR. Mr. Bryant from Texas.

Mr. BRYANT. Mr. Walters, I am under the impression from your testimony that you have had long enough tenure as Administrator at the VA to form an opinion with regard to the quality of employees and the efficiency of the overall operation. You described the hospital operation a moment ago in glowing terms and said it was a marvelous system.

I wondered if that reflects an opinion on your part, the high opinion on your part, of the quality of employees and efficiency of your overall agency in general?

Mr. WALTERS. I have been to 70 hospitals since I have been the Administrator of the VA. I have talked to a lot of veterans and employees including doctors, but mostly veterans being treated in the VA hospital care system. We have 10 letters of appreciation to 1 letter of condemnation from those who use our system. When I go to the hospital, I don't find veterans who are displeased with the quality of care they are getting. There are some, but I haven't seen them. Of course, they don't necessarily get them out there for the Administrator, either, Mr. Bryant, when he comes through.

I think if a veteran is sick and he's not getting good care, he's going to tell you. I found that veterans like our care. Our critics are normally those who don't use the system.

Mr. BRYANT. Do you attribute——

Mr. WALTERS. In that regard, I would say it's a marvelous system, based upon my personal exposure to it.

Mr. BRYANT. Do you credit the employees of the VA for the quality of the system?

Mr. WALTERS. Of course. I credit history, this Committee, the Senate Veterans' Affairs Committee, General Omar Bradley, who was wise enough to affiliate with medical colleges across the country in 1946.

Mr. **Bryant**. I wonder if you believe the employees of the Veterans' Administration deserve a 5-percent pay cut as has been proposed by the President?

Mr. **Walters**. I'll tell you, I'm not really interested in a 5-perecent pay cut myself. I have a wife, family, a budget, the whole deal, you know. It's tough.

A five-percent pay cut is something that happens in every corporation.

Mr. **Bryant**. No, I just asked you if you——

Mr. **Walters**. Well, I just want to make it clear to you, if a corporation I owned—and I owned some—was going bust, a 5-percent pay cut wouldn't be something we would ask for; it would be something I would do.

Now, that is where the Administration is coming out on the 5-percent pay cut. The infinite wisdom of that is certainly that a 5-percent pay cut is not what we normally would consider a morale builder. If that's your question, then clearly we can say the 5-percent pay cut is not a morale builder. But worse things have happened to people than having 5-percent pay cuts. The morale factor of the VA belongs to us, as managers. We need to keep our morale up, whether we give them a 5- or 10-percent increase or 3-percent decreases.

Mr. **Bryant**. Do you support the 5-percent pay cut for your employees?

Mr. **Walters**. I think I could support the 5-percent pay cut if everyone in Government got it, and it was equitably distributed across the system. That includes me, by the way.

Mr. **Bryant**. You used an analogy——

Mr. **Walters**. I'm not going to go for 10 percent. I'm just going for 5.

Mr. **Bryant**. You used an analogy suggesting that if a company is going broke, perhaps cutting everybody's pay is necessary. Usually that is because it's viewed that somehow there was a problem in the performance of the company and, therefore, their pay should be cut.

Do you think there has been a problem in the performance of your employees that would merit a 5-percent pay cut?

Mr. **Walters**. I don't buy your hypothesis, first of all, because if I owned a company——

Mr. **Bryant**. It wasn't a hypothesis. I was just suggesting to you that perhaps the example——

Mr. **Walters** [continuing]. If I owned a company where, for example, the James River flooded——

Mr. **Bryant** [continuing]. The example that you offer could have been—Mr. Chairman, could I please ask the questions?

Mr. **McEwen**. Could the witness be permitted to respond, Mr. Chairman?

Mr. **Edgar**. The Chair will have some order in the room. We need one at a time.

I yield to my colleague, Mr. Bryant, and then I will yield to Mr. Walters for a response.

Mr. **Bryant**. Mr. Walters, I was elaborating on my example simply to say that, if the analogy you gave is to be followed, usually the reason that you cut people's pay is because there has been a failure of some performance in the company. You then characterized my analogoy as a hypothesis. I did not hypothesize anything. I just drew on your analogy and expanded upon it, to suggest that maybe it wasn't a full analogy. I think the full analogy would be the one that I gave.

If the company has had a failure of performance of some type, then clearly everybody should tighten their belts to make up for that problem. I wonder if you feel there has been a failure of performance at the VA that would have earned everybody a 5 percent pay cut or not.

Mr. **Walters**. I think the VA employees are as well paid as anyone in the Government, and I think we could consider many of them to be overpaid at any one given point in time. As Administrator, I have to administer a law that says we are going to distribute moneys for nurses and special pay to different people. I find many times we're behind the power curve in that arena and that we are paying moneys to somebody in order to equalize a given market, that we are behind the power curve and now we have to withdraw. I am required by law to do that. So it is not unusual—in fact, we're doing that this year—to take special pay incentives and move them around. Some people are not going to get a special pay incentive this year. It's a management tool that is available to me by law, and I use it. I suggest a 5-percent pay cut, as proposed to the Congress, is a management tool for the reduction of the Federal deficit.

Other than that, I have no more comments to make on this subject.

Mr. **Edgar**. Let me just ask the question one more time for a yes or no answer. Do you support the 5-percent pay cut that is proposed in the VA budget?

Mr. **Walters**. I do support the 5-percent pay cut as proposed in the VA budget, because it is across Government, equitable and even.

Mr. **Edgar**. Thank you.

Mr. McEwen.

Mr. **McEwen**. Thank you, Mr. Chairman.

It is customary, Mr. Walters, when we have witnesses to express our appreciation for their coming and our gratitude for their presentation. I am going to do that as well. But I want you to know that it is not just a pro forma expression of thanks. I have genuine appreciation for the leadership that you have brought to the Veterans' Administration. And for the fact that you are a constant champion and supporter of the veteran. I believe that has been much needed in our country, especially after more than one decade of lack of appreciation that the Chairman referred to some moments ago, as to the condition of the VA hospitals and the level of priorities in which they were placed by previous Congresses. You oversee a department that has many, as you pointed out, facilities that are much in need of updating and repair. And I think you have done a commendable job in trying circumstances.

As a Congressman who oversees a staff of 12 people, and has a workload of about 100,000 letters a year, to think you operate a system with over 220,000 employees and millions of individual records on 1940's technology, is a most commendable task. I have undertaken, during the month of January, the task of culling our files, to go back to make sure we have people's names spelled right and their addresses correct—that it's a road and not a boulevard, et cetera—and the number of mistakes that I found in my little shop compared to what you must go through makes me admire you even all the more.

As I, in my operation, look for one thing, I look for attitude among the people that I have on my staff. The contribution that you have made to the Veterans' Administration through its employees and its services, and your leadership in the attitude that you have brought to the Veterans' Administration, and your fine deputy, Everett Alvarez, is something for which I, as an American and a member of this committee, am most grateful for.

Let me pose one final question, in response to a letter that I have several hundred of in my office, that have been received in the last few weeks. I will read just two sentences.

It says:

> I am writing in response to our national commander's request that we write our Senators and Congressmen in regards to the proposed taxing of veterans compensation and pensions and the taxing of Social Security benefits that the Reagan administration has proposed. Being a dependent veteran that has served our country honorably, I am appalled at the proposals that are being implemented into our system concerning senior citizens and the disabled veteran.

As the veterans Administrator, can you point out to me where in your policies you have implemented such a system of taxing compensation of disabled veterans, where in the budget, if anywhere this appears, or any other action on your part that would motivate an organization to write a letter of this type to me?

Mr. WALTERS. Well, I haven't seen the letter, Mr. McEwen. In all due respect to you, I don't want to speak off the top of my head to such a serious matter. I would like to see a copy of the letter and I will certainly give you my views in writing.

To my knowledge, I have not subscribed or have been guilty of any of the above.

Mr. MCEWEN. Is there anything in the budget that I have overlooked that proposes the taxing of disabled veterans compensation?

Mr. WALTERS. Not in the budget, no.

Mr. MCEWEN. And you have no knowledge as to where such an attack could originate from, or what would prompt such an attack?

Mr. WALTERS. I think the tax simplification package that Congressman Smith mentioned is probably what this letter is referring to.

Mr. MCEWEN. But you have no such individual proposal by the Veterans' Administration?

Mr. WALTERS. No, none whatsoever.

Mr. MCEWEN. Do you have any knowledge of any other proposal that the White House has proposed similar to this?

Mr. WALTERS. I know of no proposal that is formalized and sent to the Congress where veterans would be taxed, except the one that we hear about, that the Secretary of the Treasury had asked for a study. That is one of many proposals that is being studied, and I have no idea how that is going to turn out.

I have already indicated what I thought about taxing veterans benefits.

Mr. MCEWEN. Thank you very much.

Mr. **Edgar**. Thank you.

Ms. Marcy Kaptur.

Ms. **Kaptur**. Thank you, Mr. Chairman.

I have three concerns, some of which have been alluded to by others this morning, and I will just tick them off very quickly. The first one is the means test, the second one the whole question of insurance, and the third one, for lack of a better term right now, I will just call quality care.

On the first one, the means test, I would hope that, though you have no details right now on the criteria for nonservice-connected veterans—and we have heard your opinions on the 65-year-old age threshold—that the Chair of our committee would hold extensive hearings at such time as you would be able to provide us with specific information on the administration's proposal.

Do you have any idea when that might be, please?

Mr. **Walters**. Within a week or two, I suspect, we should be able to propose legislation with a means test.

My Acting General Counsel is here. Bob, how close am I to that target?

Mr. **Coy**. In the next 2 or 3 weeks we'll try to get it to you. At least we'll do the best we can.

Ms. **Kaptur**. All right. Though you can't tick off the specifics, could you give me some of the principles beyond the ones of fairness and equity and all the rest? What has been the problem between the Veterans' Administration and OMB? You have been going back and forth. What are the principles that are in dispute?

Mr. **Walters**. If I might—that's a very good question. The problem has emanated with a 1980 law which authorized the VA Administrator to deliver a means test to veterans under the age of 65. From that point on, until now, the VA and the OMB have been arguing about what kind of means test that might be. The fact is we are authorized to do it. So this year, we were directed to put one together. We were going to do it for fiscal year 1985, but OMB and VA both realized and thought it would be in the best interest to take a good look at that whole arena of over age 65 legislation. I think the Congress has to look at it in the sunlight with us. I think that is what we're proposing that you do.

Now, in terms of the means test itself. The means test, as we will propose it, will be fair to some and not fair to others, depending on your viewpoint. The means test is not a very delightful thing to sit and talk about, quite obviously. But I think we have eliminated many veterans from a means test; all service-connected veterans, even service-connected veterans with non-service-connected disabilities will be eliminated.

Ms. **Kaptur**. As far as the total number of veterans, what percent ballpark would be affected by a means test, then, based on the number that are eliminated?

Mr. **Walters**. Well, when we get right down to the nub, at this point in time we're talking about less than 20 percent of all the veterans coming to the hospital. John, is that about right?

Dr. **Ditzler**. Probably.

Ms. **Kaptur**. About 20 percent.

Mr. **Walters**. I would say 20 percent.

Ms. **Kaptur**. Thank you for that.

Moving on to this insurance which is another area I hope the committee will get into in some detail. I would echo many of Mr. Bilirakis' questions which are also on my list here. I know even with the Medicare coverage and the opportunities for senior citizens to obtain supplementary coverage, I have been enlightened in my short period in office by how confusing insurance is to seniors, the types of policies, the variety that are available. We have lots of movie stars selling supplementary coverage. It is hard for them to really—many of them don't even know that they don't have supplementary coverage, so when you get into this whole area of insurance, it really gets to become a kind of a thicket.

I also am concerned about the relation to Medicare and Medicaid. I understand from some numbers that we have here, materials that were submitted to us, almost two-thirds of patients receiving care in VA hospitals have no health insurance at all; that about 16 percent qualify for Medicare and another 15 percent have some private health insurance.

I don't know what that means for you, and I don't know what the real budget impact is, but as you move into this third party payment system, both administratively, the way that it's set up, and its relationship to other programs, the amount of dollars that it would really yield to help us on the bottom line, I don't really know. I wonder if you're not going to have as many problems once you get into it as you have right now.

Mr. WALTERS. I guess I could share your views, that I would be concerned that the cost of implementing it would not return enough to take care of the costs. We have been concerned about that. That question is asked often. At this present time, it certainly doesn't appear that many of our veterans have insurance coverage.

Ms. KAPTUR. I would just like to ask the Chair to make sure that the exhaustive hearings that we will have on the means test will be echoed on the insurance side, because I, as one Member, would be very interested in that.

Mr. EDGAR. The Chairman has a reputation of exhausting hearings. [Laughter.]

Would the gentlewoman yield at that point?

Ms. KAPTUR. Yes.

Mr. EDGAR. Mr. Administrator, I have a letter here that found its way to me, dated February 15, from the Office of Management and Budget, and it is to Mr. Gary Cole, the Budget Director of the VA. It is from Susan Jacobs, Chief, Veterans Affairs Branch, Veterans and Labor Division of the Office of Management and Budget.

This is a document that may, in fact, be a draft, but it sounds like in the cover letter that these points have been agreed to. One is in an area that the gentlewoman from Ohio is speaking of. Let me just read one of the points under the heading of "VA Eligibility Program—Additional Points of Clarification." This is the understanding that is trying to be reached between OMB and your department.

It says:

> VA care is not intended to be a substitute for Medicare for veterans with Medicare coverage in incomes above double the maximum VA pension rate. These veterans would first seek care available to them through their Medicare coverage. However, after these veterans make out-of-pocket expenditures up to their expected med-

ical expense contribution, they will be eligible for VA care. Veterans with Medicare eligibility and incomes below double the pension level will be admitted to the VA, whether or not they have first used their Medicare benefits.

What I understand from that working point is that if there is a veteran who qualifies for Medicare, they will first have to seek their hospital care through that process before they are admitted to the VA. Is that your understanding of that working point?

Mr. **Walters**. I am very pleased that you have this working document from the VA because that is the working document that just worked its way up to my desk. I'm not very familiar with the working document.

Mr. **Edgar**. I'll give you a copy.

Mr. **Walters**. You're obviously more familiar than I. Congratulations on your intelligence effort.

Mr. **Edgar**. Let's just talk about the issue of Medicare.

Mr. **Walters**. I would like to be able to research that and come back with an answer to your question, because it's a very serious matter.

Mr. **Edgar**. It is real important for us to understand because it was indicated earlier that Medicare would not be involved, and yet, when you couple third party reimbursement with a means test, and you have as one of your possible working points that you have got to buy down your Medicare before you're going to be eligible for veterans benefits, that could be very troubling to those of us in Congress and it could be very troubling to the veteran.

[Subsequently, the Veterans' Administration furnished the following information:]

The proposed means test would function in the following manner:

Nonservice-connected veterans whose annual family incomes including assets (as defined in the Improved Pension Program) are below double the maximum annual VA pension rate based on family size, would be deemed unable to defray necessary medical expenses. Out of the pocket medical expenses for other family members would reduce the gross family income for determining eligibility.

For nonservice-connected veterans whose gross annual family incomes including assets are in excess of double the maximum VA pension rate, procedures would be established by regulation identifying the conditions under which veterans may be considered unable to defray further expenses and VA care could be provided for a particular medical service.

Except for veterans requiring emergency care and care in certain extraordinary circumstances, such veterans would not be eligible for VA health care until the veteran's out-of-pocket medical expenses exceed certain levels. These medical expense levels are termed the "expected medical expense contribution."

The expected medical expense contribution would form the basis of a means test procedure to evaluate the veteran's inability to defray further medical costs.

The following schedular display would be used.

Income interval as a percent of double the pension maximum annual rate:	Expected medical expense contribution as a percent of income in excess of double the pension maximum annual rate:
100-116.7	25
116.8-133.3	35
133.4-200.0	50
200.1-566.7	75
566.8-and over	90

If the veteran presented reasonable evidence that out-of-pocket payments for his/her care to private providers and third parties during the preceding 12 months equaled or surpassed the expected medical expense contribution, the veteran would be admitted. The precise evidence acceptable to VA pertinent to such claims would be defined in regulations.

Veterans requiring emergency care and care in certain extraordinary circumstances could be admitted for VA care, but would be billed for the cost of such care up to their expected medical expense contribution. These terms would be further defined in regulations. In addition, the veteran would be billed up to his expected medical expense contribution for any examination provided to determine if emergency care is required.

For treatment of these nonservice-connected veterans, if the veteran is covered by a private insurance plan, the private plan would be required to reimburse the VA for medical expenses incurred by the patient that are covered by the plan. The VA would bill the veteran the difference between the insurance company payments and actual VA costs, but not in excess of the veteran's expected medical expense contribution.

WAIVER AUTHORITY

In exceptional, unusual, and rare circumstances, the Administrator could waive the veteran's expected medical expense contribution.

The Administrator would have authority to grant waivers for a portion or all of an individual veteran's medical expense contribution limited to the period of the episode of care for which the veteran claimed relief. Such waivers would only be considered upon application of the individual veteran, and a demonstration by the veteran that the contribution would effect an unusual and exceptional hardship on the veteran. Such waivers will not be granted categorically, either for categories of illness, expenses, incomes, procedures, or for veterans. The Administrator would issue regulations setting forth the procedures for granting such waivers. The Administrator's decision to grant or not to grant a waiver would not be subject to judicial review.

GRANDFATHER CLAUSE

This new procedure would be implemented prospectively; VA would not apply the means test for patients in a treatment status at the time of implementation of such new procedures. This grandfather provision would apply only through the duration of the episode of care.

Mr. EDGAR. I thank the gentlewoman for yielding. If she has additional questions, she may ask them.

Ms. KAPTUR. The third point I just wanted to make on quality care. I will have to go back and read, but perhaps Mr. Walters could inform me. As far as the number of veterans served in any given year by the VA, what percent are nonservice connected, both in your inpatient and outpatient services?

Mr. WALTERS. It's somewhere around 51 percent inpatient, if I'm not mistaken. Outpatient for fiscal year 1984 was 50.5 percent nonservice-connected.

Ms. KAPTUR. So it's at least half, at least half?

Dr. DITZLER. The question of service connected versus nonservice connected doesn't reflect the issue of mandated care, irrespective of whether they're nonservice connected or not.

Ms. KAPTUR. Run that by me again.

Dr. DITZLER. A non-service-connected veteran could be an ex-prisoner of war, he could be a veteran claiming disability due to Agent Orange, he could be a veteran claiming to have radiation exposure. All of those could be non-service-connected veterans that we considered mandated for care by previous actions of the Congress.

So separating out nonservice connected from service connected, belies in part the efforts we are required to do. It is correct, that about 32 percent of all inpatient veterans seen are purely service connected. But the remainder of those who are nonservice connected also comprise a large part of mandated care.

Ms. **Kaptur**. I was trying to draw a relationship in my mind between whatever that number is and the means test that we will ultimatly be reviewing.

Dr. **Ditzler**. The problem we have is trying to decide the non-service-connected issue. There are a large number of non-service-connected veterans who are by law, or at least from the expression of the Congress, eligible for VA medical care.

Mr. **Walters**. We would be happy to supply more information on that question for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

We anticipate that the means test will enable us to direct the VA health care capacity toward service-connected veterans, former POWs, veterans exposed to Agent Orange or ionizing radiation, pensioners, WWI, Spanish American War, Mexican border period, and other nonservice-connected veterans who are truly needy.

Veterans in these groups are represented as follows:

1. Service-connected	3,760,335
2. Pension	780,515
3. POW	84,000
4. Atomic	200,000
5. Agent Orange	166,653
6. World War I (Total minus C&P)	183,000
7. Spanish American War and Mexican Border Period (Total minus C&P)	260
8. Non-service connected with limited incomes	5,864,000
Total	11,038,903

Note: Double counting exists to some degree for POWs, Agent Orange and Ionizing Radiation.

Source: 1, 2, 6, and 7: Administrator's Annual Report 1983; 3: DVB Tapes; 4: DM&S/Defense Nuclear Agency Estimate; 5: DM&S Examinations; and 8: Office of Reports and Statistics Report, Dec. 1984.

Ms. **Kaptur**. I am sure it will come up in our discussion on the means test, but I know it is a question I have in my own mind. Who is really going to be impacted by the proposal as we review it?

Thank you, Mr. Chairman.

Mr. **Edgar**. Thank you.

Mr. Mollohan from West Virginia.

Mr. **Mollohan**. Thank you, Mr. Chairman.

Understandably, Mr. Walters, there is great concern across the whole country—and not only among veterans groups but in general—with the proposal to increase the Veteran home loan guaranty user fee to 5 percent. Congress addressed this question last year in the Deficit Reduction Act and was concerned about the solvency of the loan guarantee program.

We also, I think, reaffirmed our commitment to the viability of that program, and I don't think Congress intends to allow the administration, OMB or the Veterans' Administration to terminate the loan guarantee program.

You have already addressed this, but I would like for you to elaborate. What do you believe would be the impact of a 5-percent user fee on this important program?

Mr. **Walters**. Well, my belief, and that's all it is, because we're dealing with conjecture for the future——

Mr. **Mollohan**. That's all I'm asking for.

Mr. WALTERS. It's just speculation—is that it will cause certain veterans to fall above the level, monthly payment-wise, that they're going to be able to afford. Just how many veterans that will be, I'm going to ask Mr. Hagan, who is our Acting Chief Benefits Director and has a working knowledge of this. If you want to call on Mr. O'Toole, and pass that on, you can.

Mr. HAGAN. Thank you, and I will do so.

Mr. WALTERS. With your permission, Mr. Mollohan.

Mr. MOLLOHAN. What are you doing here with——

Mr. WALTERS. I would like to answer the question with Mr. Hagan or Mr. O'Toole.

Mr. MOLLOHAN. Well, I would appreciate having your assessment of it, and then if you would like for somebody else——

Mr. WALTERS. I have given you all I can give you at this point.

Mr. MOLLOHAN. Well, let me follow up with you for just a minute then.

In making this proposal, have you run any numbers? Obviously, there's an incremental dropout in the marketplace for every increase in price for a service or a commodity. Have you undertaken a study to determine how many veterans would drop out of the program with this rather dramatic increase in the price of the program?

Mr. WALTERS. We have done some work in that area. Again, I would refer to Mr. Hagan, who has that knowledge right on the top of his head, hopefully.

Mr. EDGAR. Would the gentleman yield before we hear the answer?

Mr. MOLLOHAN. Yes, Mr. Chairman.

Mr. EDGAR. Could we ask a direct question, Mr. Walters. Do you support the proposal that has been brought up in the budget of the 5 percent on these loans?

Mr. WALTERS. I support it. I support the 5-percent fee because $400 million is required to balance that fund. I support it reluctantly. I support it reluctantly, agreed, but I think with the same caution you ought to look at it as well. It's a $400 million deficit in that account, and every year it looks like it's going to grow. I think we have a problem here and——

Mr. EDGAR. I just wanted to be clear whether or not you're in support of it.

Mr. WALTERS. Absolutely.

Mr. EDGAR. You're absolutely in support of it, and I yield back to the gentleman.

Mr. MOLLOHAN. Thank you.

You keep referring to a $400 million deficit and the need to generate $400 million. How do you generate that number?

Mr. WALTERS. That's a very good question, Mr. Mollohan, and——

Mr. MOLLOHAN. Thank you, and I would appreciate your——

Mr. WALTERS. It's a very complex formula. I would be happy to supply that for the record for you. It has to do with foreclosures and other items.

Mr. MOLLOHAN. Well, let me just ask about the figures. Are they based upon the 5-percent fee, or is it based on the 1-percent fee which Congress approved in the Deficit Reduction Act? What's the base fee that you use to generate your numbers?

Mr. Walters. The 1 percent is the fee which led us to a $400 million number. The 5-percent should make up that $400 million.

Mr. Mollohan. How much money do you believe that the 5-percent fee would generate, based upon the estimates that you have of the people participating in the program?

Mr. Walters. Approximately $400 million.

Mr. Mollohan. I run those numbers and I get $600 million.

Mr. Walters. Again, I would like to supply for the record those numbers, so that I can explain more clearly, and from the top of my head. It's a very important matter.

Mr. Mollohan. Let me just ask you one more question.

Do you assume, when you run those numbers, that the same number of people will stay in the program, or do you assume there will be that incremental dropout with each increase?

Mr. Walters. We show a sliding scale.

Mr. Mollohan. OK. Well, I would be interested in hearing Mr. Hagan's off the top of the head comments.

Mr. Walters. Mr. Hagan's comments may be much better than mine. This topic is nearer and dearer to him in his normal everyday duties.

Mr. Hagan. Mr. Congressman, I really don't know if there is anything additionally that I can add. The Administrator has responded saying that this 5-percent fee would produce approximately $400 million.

Mr. Mollohan. Do you agree with that?

Mr. Hagan. Yes, I do.

Mr. Mollohan. With the 5-percent figure?

Mr. Hagan. Yes.

Mr. Mollohan. So you agree, if you multiply that 5 percent by the 220,000 people that you estimate will be in the program in 1986, that you come up with $400 or $600 million? Have you run those numbers?

Mr. Hagan. Yes, the numbers have been run within the Department. I don't know what your average——

Mr. Mollohan. It's not averaging. It's just multiplying.

Mr. Edgar. Would the gentleman yield at that point?

Mr. Hagan. Yes, sir.

Mr. Edgar. I'm confused.

Mr. Mollohan. I am, too, Mr. Chairman, because——

Mr. Edgar. At 1 percent we estimate there will be 225,000 people coming into the program next year; is that correct?

Mr. Hagan. Yes.

Mr. Edgar. The Administrator just said that there's going to be a sliding scale if you put it up to 5 percent. It sounds more like it's going to be a cliff, OK? You fall off in your number of applications.

I don't think it is real accurate, is it, to give us numbers based on that 225,000 participation if, in fact, you increase the fee from 1 percent to 5 percent. Aren't we going to see a dramatic cutoff, perhaps as much as half, of the participation level, and won't that, in fact, cause less funds to come into the system?

Mr. Hagan. Mr. O'Toole.

Mr. Edgar. Mr. O'Toole, if you will please speak into the microphone, turn it on, and give your full name and title.

Mr. O'Toole. Mr. Chairman, I am Bob O'Toole, the director of the Loan Guaranty Service.

The budget estimates that loan originations will remain the same, whether the fee is 1 percent or whether it's 5 percent.

Mr. Edgar. Is that true if it goes to 10, 15, or 20 percent?

Mr. O'Toole. We didn't do an estimate on higher amounts.

Mr. Edgar. What makes you think it is going to stay the same if you have the exponential increase in cost that you're estimating? Do you think——

Mr. O'Toole. I think, as the Administrator has indicated, we're not sure what the impact will be. Certainly there is a feeling in the agency that there will be some impact on originations.

Mr. Mollohan. Mr. Chairman, I heard the Administrator say that the estimates assumed a reduction in participation in the program. Did I mishear that? You're saying something different.

Mr. Walters. What I indicated was, it was my understanding that we had run numbers indicating what the fee would bring.

Mr. Mollohan. Well, based upon what this gentleman has just said, is your understanding correct or incorrect?

Mr. O'Toole. I don't think we're in disagreement.

Mr. Mollohan. Well, you say that you do not assume a reduction, and the Administrator said he assumes there is a reduction. So I would say that's a difference.

Mr. O'Toole. In the negotiations between the VA and OMB, there was a slight difference of opinion on what the impact of that fee would be.

Mr. Mollohan. What was that difference of opinion?

Mr. O'Toole. The agency's estimate was it would be about a 50-percent falloff in originations.

Mr. Mollohan. What was OMB's estimate?

Mr. O'Toole. It was approximately a 1 percent falloff.

Mr. Edgar. You're saying 50 percent and they're saying one percent.

Mr. O'Toole. That was an early estimate. Since there has been a bit more public comment, I'm not sure that 50 percent is a good figure.

Mr. Mollohan. Which way are you——

Mr. Edgar. Let's take a figure of—if the gentleman would yield—of 25 percent. Let's say there's a 25 percent falloff in the figure. What numbers would we get at that point? That is half of your estimate originally and 24 percent more than what OMB had thought it would be.

Mr. O'Toole. A 25-percent falloff, keeping the 5 percent fee?

Mr. Edgar. That's right. It would be one-quarter of the amount of money that you're projecting, wouldn't it?

Mr. O'Toole. That's right, and then you would have to estimate what impact that would have on the number of originations. We could certainly do that.

Mr. Edgar. I am suggesting there would be a 25-percent falloff of originations.

Mr. O'Toole. Then you would have to take 25 percent off the income that we were projecting for the fee.

Mr. **Walters**. $300 million. It should be a straight line reduction.

Mr. O'**Toole**. Yes.

Mr. **Walters**. That's what I thought we had done. The arithmetic seemed to be pretty simple.

Mr. **Edgar**. I yield back to the gentleman.

Mr. **Mollohan**. Thank you, Mr. Chairman.

Am I right, that a 5-percent fee, if you're talking about a $60,000 average loan, would amount to about $3,000?

Mr. O'**Toole**. That's right.

Mr. **Mollohan**. And if you multiply $3,000 times 220,000, which is what you project for participation in 1986, you would get over $600 million, and you're saying you need $400 million.

Mr. O'**Toole**. That's right.

Mr. **Mollohan**. So the 5 percent generates, according to your numbers, a significantly higher amount of money than you're representing you need; is that correct?

Mr. O'**Toole**. Mr. Mollohan, the budget indicates that a $200 million income will be generated over what would be needed to finance the shortfall in the fund in fiscal year 1986.

Mr. **Mollohan**. That's my point. Thank you.

There are so many questions and so little time, Mr. Chairman, may I submit the remaining questions I have for the record?

Mr. **Edgar**. Without objection.

Mr. **Mollohan**. Thank you.

Mr. **Edgar**. Mr. Gray.

Mr. **Gray**. Thank you, Mr. Chairman.

Mr. Administrator, I am a strong supporter of your administration, but I have two things that came to my attention yesterday that disturb me very much.

One was on Medicare, stating that a Cairo, IL hospital—that patients were being cut off because they did not have adequate fire protection. About 2 hours later I received a call from an employee of the Veterans' Administration Medical Center in Marion, IL saying that the fire department there was being abolished. This is grossly inconsistent.

I was wondering if it portrayed any kind of a trend in the administration of eliminating fire departments. This particular facility is 42 years old. They have their own in-house fire department. Ironically, with the elimination of the fire department yesterday, a firetruck that had been on order for 5 years showed up, was loaded back on the truck and sent back to the factory.

I would like to have your comment on that particular situation.

Mr. **Walters**. I would have to provide an answer for the record. I'm not familiar exactly with the details of that incident.

Mr. **Gray**. But the main thrust of the question is, though, Mr. Administrator, does this indicate any trend of eliminating fire departments in your institutions?

Mr. **Walters**. Not to my knowledge, but Dr. Ditzler may have more information.

Dr. **Ditzler**. We try to get the necessary fire support that is required for a hospital. If the community can provide fire protection services, fire departments of our own are discontinued.

I can't address this specific issue because I don't know whether there's a change in the Marion, IL community.

Mr. GRAY. The population is 10,000 and the fire department is some 2 miles away. As I say, for 42 years we had in-house fire protection. Of course, naturally, the VA employees are very much disturbed about it. I will write you a letter on it.

I just wondered whether that was indicating any kind of a trend, as to whether you're going to try to consolidate with the local communities and eliminate your own in-house fire protection.

Dr. DITZLER. The trend is to use available community resources.

Mr. GRAY. Of course, the community has been available for 42 years and the VA hasn't seen fit to use the community up until now. As I said, a further indication of that was that they had a firetruck on order for 5 years which showed up yesterday, and it was loaded back up and taken out of town.

Dr. DITZLER. I would like to provide that information to you, sir.

Mr. GRAY. I would appreciate it very much.

Thank you, Mr. Chairman.

[Subsequently, the Veterans' Administration furnished the following information:]

A fire protection study of both the VAMC Marion, Illinois fire department and the Marion, Illinois fire department was conducted by a private consultant using the VA's fire protection criteria as contained in MP-3, Part 3, Part 3. The consultant's review and findings determined that the Marion, Illinois fire department's capability had significantly improved over recent years to the point of meeting the VA's criteria for reliance on community fire protection services. Based on those findings, it was determioned that use of the Marion, Illinois fire department would provide for an equivalent or better level of fire protection for the VAMC.

Since the VA's criteria for fire departments requires an established level of fire department capability either via a community fire department or by establishing an equivalent level of in-house fire department capability, the level of fire protection provided via either method is at least equivalent; hence there is no adverse effect on a VAMC when a shift is made to a community based fire department. This approach does not even take into account the potential cost savings to the government when a community based fire department is used in lieu of an in-house fire department. Every reasonable attempt is being made by the VAMC Marion to provide employment opportunities for its firemen who wil be affected by the shift to the community based fire department.

The fire truck in question had been ordered for the VAMC Marion fire department last year prior to the above discussed consultant study. After the decision was made to utilize the Marion, Illinois fire department, the VA ordered the fire truck to be shipped to the VA medical facility next on its prioritized list of fire departments in need of equipment replacement, namely, VAMC Hot Springs. However, neither the Navy Procurement Office (responsible for group purchase of fire trucks for the government at a cost savings) nor the supplier (Walters Equipment Corporation) were able to change the bill of lading for delivery in time to directly route the fire truck to VAMC Hot Springs. This was done by the VA after receipt of the truck at the VAMC Marion, Illinois. The truck was not sent back to the supplier but was transhipped to VACM Hot Springs.

Mr. EDGAR. Thank you.

Mr. Walters, let me ask you a series of questions, and we'll try to make them as brief as possible, but they're in a number of areas. Let me go back to the Home Loan Program.

Would the reduction that was indicated in usage of the program affect each State equally, in your opinion?

Mr. WALTERS. It would be almost impossible for me to sit here and speculate about that, but I would be happy to research that and provide it for the record.

Mr. EDGAR. It would be helpful if you could research what you project might be the level of decline in moving to 5 percent, whether or not there is any regional or State-by-State imbalance, in such

States as Pennsylvania, Michigan and other areas that are experiencing pockets of economic distress, whether or not they would be impacted disproportionately from other States that may be in better economic standing.

Mr. Walters. Mr. Chairman, if I might, we will supply that. But I think again we're dealing with speculation, so I preface my comments and will preface our return of the data on the basis that I think it is speculation at this point.

[Subsequently the Veterans' Administration provided the following information:]

In FY 1984 the average GI home loan amount was $87,490 is southern California. A 5 percent funding fee, if financed, would have increased the monthly payment by $37 a month.

In contrast the FY 1984 average GI loan amount was $41,734 in western Pennsylvania. A 5 percent funding fee, if financed, would have increased the monthly payment $18 a month.

The veterans in California, therefore, would have twice as much in fees than their counterparts in Pennsylvania. The California veteran, however, received twice as much no money down credit and in the event of foreclosure the VA would be more likely to sustain higher losses. In the final analysis we do not believe there would be a more severe impact on any one particular group or locality.

Mr. Edgar. While you're speculating, would you also speculate for us why the number of foreclosures on the VA Home Loan Program are so high, given the fact that the administration talks about the economy being so good? In 1984 there were 28,036 foreclosures, and in 1985 there were 26,000 foreclosures. You still estimate 22,000 foreclosures in 1986. It would be helpful for us to understand why that number of foreclosures would exist, given the so-called turnaround of the economy.

Mr. Walters. Not to argue about the so-called turnaround of the economy, because I don't know about that—I just know about the VA. The Home Loan Program is designed to start out young men and women who are veterans with their first home. That is really the basis for the program. So, having said that, we are making most loans to people who are higher credit risks than the normal American homeowner would be.

I don't have the exact data, but I know that our foreclosure rate is less than FHA foreclosures. So, from that measuring stick, I think the VA Home Loan Program performs admirably well.

We do have a higher foreclosure rate than the normal conventional loan would have, but again I go back to the fact that we are loaning money to start people out in their homes, so I think we're taking a greater risk.

Mr. Edgar. In your response for the record would you also take a look at the regional foreclosure rates to see whether there are pockets of poverty, or States that have a higher foreclosure rate than others?

Mr. Walters. Yes, sir.

[The Veterans' Administration subsequently submitted the following information:]

The primary reasons for the continued high rate of foreclosures are as follows:

The economy has not recovered equally in all areas of the country.

Many families who qualified for home loans based on their combined incomes have either lost or incurred a reduction in that income and are unable to meet their mortgage obligations.

Stable or declining values preclude delinquent borrowers from readily selling their homes to avoid foreclosure.

Previously unemployed borrowers return to jobs and can't cure their loan defaults because they have become overobligated while out of work or are now working at lower paying jobs.

Marital problems lead to a high incidence of foreclosures.

Some states have ended foreclosure moratoriums and the backlog is now being processed.

Many properties securing delinquent loans have been released from bankruptcy proceedings and are now being foreclosed.

VA FORECLOSURE RATES BY STATE CALENDAR YEAR 1984

State	Number of foreclosures	Number of loans outstanding end of year	Foreclosure rate (percent)
Alabama	506	89,887	0.563
Alaska	14	10,253	136
Arizona	704	104,585	673
Arkansas	191	31,909	599
California	2,580	582,161	443
Colorado	1,129	159,684	707
Connecticut	54	28,140	192
Delaware	42	11,825	355
District of Columbia	42	7,868	534
Florida	1,158	225,661	513
Georgia	820	147,107	557
Hawaii	55	16,163	340
Idaho	162	20,488	791
Illinois	2,326	108,122	2.151
Indiana	1,027	80,178	1.281
Iowa	495	31,551	1.569
Kansas	355	39,421	900
Kentucky	228	35,749	638
Louisiana	285	75,754	.376
Maine	50	18,410	272
Maryland	288	114,547	251
Massachusetts	41	65,441	063
Michigan	1,181	90,978	1.298
Minnesota	538	92,152	584
Mississippi	182	42,955	424
Missouri	298	68,034	438
Montana	96	14,762	650
Nebraska	172	28,642	600
Nevada	287	34,256	838
New Hampshire	23	12,969	.177
New Jersey	872	128,058	.681
New Mexico	62	25,298	.245
New York	288	174,541	.165
North Carolina	590	116,202	.508
North Dakota	84	7,280	1.154
Ohio	2,487	184,535	1.348
Oklahoma	708	71,753	.987
Oregon	139	21,415	1.120
Pennsylvania	780	102,877	.758
Puerto Rico	176	27,136	649
Rhode Island	6	2,138	.281
South Carolina	367	63,998	.573
South Dakota	28	6,213	.451
Tennessee	418	86,851	.481
Texas	3,381	434,386	.778
Utah	254	35,325	.719
Vermont	6	2,456	.244
Virginia	402	211,598	.190
Washington	1,126	80,914	1.392
West Virginia	107	11,018	.971

VA FORECLOSURE RATES BY STATE CALENDAR YEAR 1984—Continued

State	Number of foreclosures	Number of loans outstanding end of year	Foreclosure rate (percent)
Wisconsin	302	34,004	888
Wyoming	313	13,003	2.407
Total	28,225	4,221,651	669

Mr. EDGAR. Thank you.

In your opening statement, did you say that in 1986 you anticipate two nursing homes, one in Amarillo, TX and one in Tucson, AZ?

Mr. WALTERS. For the record, yes, I did.

Mr. EDGAR. Could you tell me why the Philadelphia nursing home was not in that list?

Mr. WALTERS. I think it is in the construction part of the Philadelphia modernization project, phase I.

Mr. EDGAR. But it is a 240-bed nursing home which is what is remaining of the money that was put aside for the President's budget.

Mr. WALTERS. It is in the Philadelphia modernization project, the 240-bed nursing home, yes, sir.

Mr. EDGAR. We were given information, when Dr. Ditzler was here before our committee, that while Philadelphia saw a reduction from over $100 million for 1986 to $12 million for 1986, that that $12 million would fully fund the construction of a 240-bed nursing home.

Is that correct?

Mr. WALTERS. I don't know for sure exactly how that's broken out.

Let me say this, if I might, Mr. Chairman. The Philadelphia hospital is a split funded project. We are committed until 1987 to the Philadelphia hospital. That is a split-funded project. That is my arrangement and agreement with the Office of Management and Budget. So the 1986 numbers are reflective of a start. The 1987 numbers are intended to finish it.

Mr. EDGAR. Could you or someone on your staff tell us what the $12 million buys in 1986? We were given the impression from Dr. Ditzler's testimony that the VA construction people wanted to have a project that started and finished in case in 1987, 1988, and 1989 there was more budget pressure, that you would have a completed project. They didn't want to start a facility and not be able to complete it.

I would like to know, what does the $12 million buy in 1986, start to finish.

Mr. WALTERS. I would like to ask a member of my staff, Mr. Chairman, Susan Livingstone, who by the way is enjoying her duties now as the official associate deputy administrator for Logistics and will be officially the Associate Deputy Administrator in the next couple of days. I welcome her to the hearings, and I hope you do, too.

Ms. LIVINGSTONE. Thank you, Mr. Walters.

Mr. **Edgar**. Thank you.

Welcome, and give us your name. The question is, what does the $12 million for Philadelphia buy?

Ms. **Livingstone**. My name is Susan Livingstone. I am the acting associate deputy administrator for logistics.

The $12 million in the budget, Mr. Chairman, will provide for the 240-bed nursing home care unit, as well as——

Mr. **Edgar**. Complete?

Ms. **Livingstone**. Complete.

Mr. **Edgar**. Start to finish?

Ms. **Livingstone**. Start to finish, as well as the surface parking that would be associated with that. I think it's about 82 spaces, as well as a connecting corridor.

Mr. **Edgar**. There was some misinformation, at least on my part, in the hearing that we had earlier, because I was assuming—wrongly so, as you are testifying—that the very needed parking facility next to the existing hospital was going to be constructed in 1986. The new word that I'm hearing today is the word "surface parking," which is only surface parking relating to that nursing home.

Ms. **Livingstone**. That's correct. The parking structure located next to the clinical addition would be in the fiscal year 1987 budget, which is the agreement we have with OMB.

Mr. **Edgar**. Do you know what the cost of that parking garage is?

Ms. **Livingstone**. I think the current estimate is about $9 or $10 million.

Mr. **Edgar**. There is a bridge that is supposed to go from the nursing home across to the parking garage which has very necessary utilities and other things within that bridge.

Is that going to be constructed in 1986?

Ms. **Livingstone**. The funding for the connecting bridge is provided in the fiscal year 1986 budget. It will have to be coordinated with the 1987 project I understand as well for connections into the parking structure.

Mr. **Edgar**. We had testimony in Dr. Ditzler's hearing that we were going to build things that had a completion to them. The problem is, with the bridge, there is nothing to connect the bridge to; is that correct?

Ms. **Livingstone**. That's correct in terms of the budgetary phasing, however, I understand the timing of the construction phasing fully provides for the bridge to be coordinated with the garage. Basically what we're trying to do is to obtain as much of the construction or completion that we could on the nursing home care site, which included the connecting bridge to the other site. In terms of the hookup, that will occur through the fiscal year 1987 budget.

Mr. **Edgar**. I would like to really go back and search the record of Dr. Ditzler's hearing, because to my knowledge, the word "surface parking" was not used, and that the impression that was left in that hearing was that that parking garage would, in fact, be included. There are four elements to the construction project: one is a nursing home facility, two is the parking garage, which is very necessary for patient and family access to a facility that has little or no parking, third is the clinical addition, and the fourth is the outpatient clinic—those four projects.

So what we're hearing today is, rather than two of the four projects being fully funded, we are really only funding one of the four projects that are a part of the modernization of the facility; is that correct?

Ms. LIVINGSTONE. The nursing home care section is funded fully in fiscal year 1986, and then it goes into the additional phase of construction, which is the clinical, the parking structure, and the renovation work at Philadelphia, and that's scheduled for fiscal year 1987 funding.

Mr. EDGAR. Are you clear that the $12 million, if, in fact, in 1987, 1988, and 1989, we come into a real budget crunch because of our deficits, that the $12 million will fully construct a usable 240-bed nursing home facility?

Ms. LIVINGSTONE. Yes, sir. I believe there is also additional savings from money that was appropriated for the project for design and site preparation in fiscal year 1985. So, given those additional moneys, combined with the fiscal year 1986 request, there should be more than sufficient funds to fully complete that facility.

Mr. EDGAR. It is helpful for you to clarify that for the record. I really appreciate that. Thank you.

Ms. LIVINGSTONE. Thank you.

Mr. MOLLOHAN. Mr. Chairman.

Mr. EDGAR. Yes.

Mr. MOLLOHAN. Could I ask about two or three very quick questions along those lines?

Mr. EDGAR. I yield to the gentleman.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

I am interested in the Clarksburg, WV clinical addition, Mr. Walters. I am wondering if, quickly, that's on schedule in accordance with last year's schedule for design and construction and completion.

Mr. WALTERS. Susan Livingstone would have that right on the tip of her tongue.

Ms. LIVINGSTONE. As far as I know, there has not been any delay in the schedule. I don't have the exact schedule for 971 milestones in front of me. However, the schedule for the construction award is, I believe, in February 1986.

Mr. MOLLOHAN. Let me ask you this. You say you believe. Do you know?

Ms. LIVINGSTONE. Well, the current schedule for the construction award is now February 1986. What I don't have in front of me is the original schedule to see if there has been a month or two of slippage in that award.

Mr. MOLLOHAN. Could you check on that and let me know, please?

Ms. LIVINGSTONE. Certainly.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you very much.

Mr. Walters, if your Agency does not go forward with the regional office reorganization proposal, will the Administration send a budget amendment to Congress rescinding the $25 million request for implementation of the proposal that is contained in the 1986 budget, and will you request a restoration of the funds for the 624 FTEE you had planned to eliminate in fiscal year 1986?

Mr. **Walters**. I don't know the answer to number one, which is the budget amendment. The second is, I think we have got to wait a bit—in fact, not too long. We have an Arthur Young study which is to be completed the end of this month. It should indicate what kind of work measurement systems are in the Department of Veterans Benefits, and if those work measurement systems are accurate, as they are now implemented. We will need to implement the recommendations of the Arthur Young study to determine just what kind of FTEE savings may or may not be available in the Department of Veterans Benefits, I haven't seen the study yet, so I don't know.

But very shortly we should have that study available to us. We ordered that about a year ago, Mr. Chairman.

Mr. **Edgar**. Thank you. It would be helpful to know that, and also it would be helpful to know the answer to the question on the budget amendment if, in fact, you don't go through with the organization.

Let me return just for a moment to the question of how Medicare will impact on both the health care and third party reimbursement, and the means test. Mr. Walters, when I listened to Dr. Ditzler earlier today, it sounded to me like he was saying that Medicare only covers inpatient costs. Could I ask Dr. Ditzler whether or not he made that statement, or if that is his understanding?

Dr. **Ditzler**. That was my understanding, but I really don't think we have explored the Medicare issue.

Mr. **Edgar**. I wonder if for the record you might clarify what Part B of Medicare covers and estimate how this coverage might affect eligibility within the VA.

Mr. **Walters**. Yes, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

Part B of Medicare covers basically outpatient medical services. An annual deductible of $75 and a co-payment of 20 percent of the reasonable charges covered by Part B Medicare are paid by the beneficiary. The fact that a veteran has any type of insurance coverage, including Medicare Part B, would not be a factor in determining his/her eligibility under our proposed means test.

Mr. **Edgar**. Mr. Walters, you have a reputation which is well deserved, and it showed up today, of being a man who speaks his mind and speaks as clearly as possible. I wonder if, in all candor and in all honesty, you believe that the budget that was sent up by the administration is a complete reflection of what you think will best serve the VA. I wonder if you could speak in terms of your own personal opinion here whether or not there are any items in this budget which you believe may, in fact, hamper quality of service and care provided by the VA.

Mr. **Walters**. Well, my good Chief Medical Director advises me that the budget we are submitting is not going to hamper the quality of care, so I rely upon his significant knowledge of the VA medical care system for that input.

From my own personal view, I live in a real world. I do not live in a world where you have all you would like to have. Mr. Chairman, I always make the analogy between my wife and the VA's budget. My wife's needs are always more than what I can budget for, and she has learned how to live at 10 percent more than I bring in. As a matter of fact, budgeting is a very difficult matter no matter how you go about it. So in the real world, we will never be able to budget for all the needs of all of our veterans, and I think we all sort of know that, unfortunately.

So, having said that, we have to deal with the pragmatics of what financing is available at any one given point in time. Based upon the practical environment in which I deal with this budget for fiscal year 1986, frankly, I think the VA was treated quite fairly under those circumstances. It certainly was treated a lot better than the Small Business Administration, I must tell you.

Mr. EDGAR. No one in OMB had suggested eliminating the VA, did they?

Mr. WALTERS. If they did, they're not alive. [Laughter.]

Mr. EDGAR. Could you identify for the record your contact person at the Office of Management and Budget? Who is the person that you go to?

Mr. WALTERS. I talk to Mr. Wright or Mr. Stockman, depending on the issue. That's the level at which I deal with OMB.

Mr. EDGAR. You have indicated your full support of the budget that is here, given the reality of life as we know it. That includes a 5-percent across-the-board salary cut; it includes a means test; it includes third-party reimbursement; it includes a reduction of employment within the VA; it includes a very fuzzy recommendation in terms of reorganization and management changes within the VA. As I understand it, you are testifying that you think this budget is a step forward and not a step backward for the VA.

Mr. WALTERS. Well, when you function in the most critical areas in this budget, you can clearly see our construction budget was not influenced much by the fiscal year 1986 austerity program. You can clearly see our medical care budget is up some $236 million. If the Congress does not pass the 5-percent pay cut, which is not health care, per se, that's a morale factor, as we discussed earlier, in fact that budget would have been almost a 6-percent increase, which is about what medical inflation is today, which is about where the VA's medical care budget has been in the last 11 years.

Mr. EDGAR. Isn't it a little bit dishonest, Mr. Walters—and I'm just asking your personal opinion—for the administration to come up here with a 5-percent pay cut, assuming that we in Congress will be beaten over the head and come back and restore that 5 percent? Isn't that a little bit dishonest? Shouldn't we be honest with——

Mr. WALTERS. I don't suggest it is dishonest. I don't suggest that asking for it is dishonest. I don't suggest that having a view that everything the administration is asking for is going to happen is very honest, either. I think there is obviously a give and take between the Congress and the executive branch, and I think we're going through that give and take here today. So I find the word "dishonest" distasteful, frankly.

Mr. EDGAR. I can understand how you could find that. But I have talked to people at the Department of Transportation, and I have talked to other agencies of Government, and every one of them is coming with the same message that you're coming with, and that is, assuming that it's across the board, but also there's an assumption that Congress is going to back off on that 5 percent because we're not going to follow through with the President's recommendation.

Mr. **Walters.** I make no assumption on that basis. If the assumption was made, then another $236 million would be available for the medical care budget in the VA. I am not making that assumption. I am presenting the President's budget. It's a $236 million increase. An increase of approximately 3 percent over last year. According to my Chief Medical Director, quality of health care delivered is not going to be affected.

Now, could we use another $500 million to treat more patients? Yes, I think so. I think we could use another $500 million to treat more patients every year.

Mr. **Edgar.** This committee is going to keep a careful eye on that question of quality of care, because you mentioned earlier the turning away of 20,000 veterans a month. My guess is, if we implement the proposals that you're suggesting in the health care area, we're not only going to be turning away larger numbers of veterans because of ineligibility based on the criteria you have laid out, but we're going to also be restricting some of the access to programs that the Congress has seen important to provide over the last 10 years.

Let me ask you some questions in the area of the elderly. You released a report late one Friday afternoon about 6 months ago entitled "Caring For The Older Veteran." In that report was a statement of the VA's understanding of the problems facing the aging veteran and its impact on the system.

Do you still stand by that particular report?

Mr. **Walters.** Certainly.

Mr. **Edgar.** Can you identify alternatives being considered for meeting the veteran nursing home care requirements, including reliance on other than VA programs, for meeting the needs for the aging veteran?

Mr. **Walters.** In general, we are doing a study on that. Chairman Montgomery asked for a recap on what the State nursing home programs were doing in the veteran community. We have asked for a recap of that and are just recapping that data now, as a matter of fact.

We are looking at what the demographics are of the private sector is building nursing homes, because we can clearly see that if we build VA nursing homes as quickly as we could build them, we probably won't be able to fulfill all of the need. I think that's true in the aging of America. I don't think frankly, all of us, including the private sector, have awaken to the fact that we're all getting older. I know it because I felt it this morning.

Mr. **Edgar.** What concrete initiatives are placed within the fiscal 1986 budget to respond to the needs of the aging as outlined in your document?

Mr. **Walters.** I will ask Dr. Ditzler, if you don't mind, Mr. Chairman, to add to my comments for the record. The 112,000 outpatient visits is a step in the right direction. We are going to continue with the GEU program, and I think the GRECC's are making progress. Although we're not going to add more, I think they are beginning to have an impact on the system. Adult day care centers will continue, and we are doing work at Loma Linda in researching and surveying the aging community.

Dr. Ditzler, perhaps you would like to add to that.

Dr. DITZLER. I would just add that we are not planning to reduce workloads and the composition of the workloads of last year will be no different, except that we will probably have more aging veterans in the group that we will already be caring for. There is a diminution in our interest, nor our care for the aging veteran.

In the aging report itself we addressed a series of alternatives that we have to look at for the future. We were primarily addressing the issue of the 1990's. I think we are quite able in 1986 to deal with the veteran population that will then be before us.

Mr. EDGAR. Dr. Ditzler, isn't it true, though, that the VA has recommended—and it has been rejected by the Office of Management and Budget—the providing of service through adult day care and some other home health care provisions, and weren't those recommendations rejected by OMB?

Dr. DITZLER. The recommendations passed back from OMB were that before we proceed to expand in those areas we had to prove they were cost effective.

Mr. EDGAR. Is that the opinion of the VA?

Dr. DITZLER. We agree that the cost effectiveness should be determined before expanding a program. Our challenge now is to prove that they are cost effective.

Mr. EDGAR. Wasn't there legislation passed in this area, mandating that the VA——

Dr. DITZLER. Correct. I believe John Mather will be able to present a full report to the committee as required.

[Subsequently, the Veterans' Administration furnished the following information:]

Public Law 98-160 mandates the VA to submit a report not later than February 1, 1988, to the Committees on Veterans Affairs containing the results of a study of the medical efficacy and cost-effectiveness of furnishing adult day health care as an alternative for nursing home care.

OMB has requested a report by March 15, 1985, of any completed and ongoing evaluations of Hospital Based Home Care, Adult Day Health Care, Geriatric Evaluation Units and Geriatric Research, Education and Clinical Centers; and specific recommendations for additional evaluations of the cost-effectiveness of these alternatives.

Mr. EDGAR. Mr. Walters, I notice in the chart on graphs for construction of State extended care facilities that in 1984 we were spending $18 million; we went to $35 million; we doubled the number because we had a backlog. We now see in the chart that we are moving back down to $22 million. We received testimony recently that indicated it would take us approximately 6 years to eliminate the present backlog. In fact, by the year 1990, we should be able to eliminate that backlog.

Was this $22 million a recommendation that the VA made to the Office of Management and Budget, or is this a number that the Office of Management and Budget returned to the VA and said this is all that you can use in this category?

Mr. WALTERS. I'm not sure what negotiated number we finally ended up with in this particular category. But there is a compounding issue here, and that is the fact that, by law, we are not allowed to award to an amount in excess of one-third of the funds appropriated in any one year.

Mr. **Edgar**. It's the one-third rule that I think you're trying to find.

Mr. **Walters**. A one-third rule, thank you.

Mr. **Edgar**. I have already introduced legislation to waive the one-third rule because I think the VA is right on that, so that we can expedite the completion.

I have also toyed with the idea—and I know your staff and my staff panic when I say this—that maybe we ought to look at some merit selection system on those facilities.

But I can tell you, in the State of Pennsylvania we have two State-related homes that are providing care at less cost to the Federal Government. Testimony we received indicated that you can provide hospital and domiciliary and other care at less cost than the Federal Government can provide it directly. There are a number of States that are considering this possibility.

When I talked to some of the State people in Pennsylvania, who I have been frustrated with because they haven't gotten their applications in, they say, "Well, gee, it's tough to put the application in if we have to wait 6 years before we're even going to be considered for that particular proposal."

If, in fact, we have a problem emerging with the aging veteran population, and if, in fact, the VA cannot afford to build many more nursing homes and facilities to care for these aging veterans, and if, in fact, it is cost effective to have a State-Federal partnership, with the State bearing 50 percent at least of the per diem cost of these veterans, doesn't it make sense for us to, rather than decrease the money in this category, to keep the level at approximately $35 million and try to reduce by one-half the number of years it takes to get rid of the backlog, so that other States might look at this program, and as we phase down our ability for the Federal Government to be a 100-percent funders of nursing home care, isn't it cost effective to allow the States to play a role?

Mr. **Walters**. I would think so.

Mr. **Edgar**. Thank you.

Dr. Donald Custis, writing in his analysis of the fiscal 1986 VA medical care budget, makes the following observation concerning the factors to be considered in a means test that is devised by the VA for non-service-connected veterans.

> The means test must contain a flexibility to accommodate geographical differentials. Living costs vary dramatically from region to region within the nation. The veteran residing in New York or San Francisco may have significantly less disposable income even with higher gross household income than a veteran living in a rural area.

In the consideration of a means test, are you developing any recommendations for a variable means test based on the regional differences in our Nation, based on cost-of-living differences?

Mr. **Walters**. I think not. I don't think that's been a consideration in the development of the means test as I know it. Would anybody here care to correct me on that?

Mr. **Edgar**. Could you ask around your staff——

Mr. **Walters**. I am correct.

Mr. **Edgar**. Why wouldn't you look at some differences, if you're looking at a means test, based on the differences of living expenses in the chairman's district in Mississippi and my district in suburban Philadelphia?

Mr. **Walters**. Miss Quandt is our resident expert here, Mr. Chairman.

Ms. **Quandt**. Having just whispered to him that he was correct, I will now attempt to answer.

The means test will look at the veteran's family income, based on a system not unlike what you're familiar with, the Pension Program. Because of the fact that there are differences in expenses from area to area, one would assume that veterans in Mississippi—and we know this to be true—do not have income levels similar to those income levels in Pennsylvania or other high cost areas. Therefore, geographic differences will probably be taken care of for those veterans.

Mr. **Edgar**. Could you repeat that again? What are you saying?

Ms. **Quandt**. I'm saying the geographic difference, based on the income levels, will have taken care of the veteran who falls within two times the pension level. Probably in Mississippi, a greater percentage are going to fall below $15,000 than will happen to those who are, say, in Philadelphia or New York. For those who are in Philadelphia and New York, we first look at the family expense, subtract from that family expense their health insurance expense, look at the net family income, and then consider what is called the contribution of the veteran to his health care before we would consider him eligible.

On that basis, we are not building geographic differences into the means test.

Mr. **Edgar**. We are going to do some looking at that from the perspective of the committee because I'm not certain the geographical differences and the income levels in those areas actually equate. If you are living solely on Social Security in Mississippi, and solely on Social Security in suburban Philadelphia, your buying power is substantially different in those two areas. I would assume that those folks who are living in those two areas might have a difficult time.

Let me ask just a couple of other closing kinds of questions.

Let's take a veteran who comes to the hospital. He is brought into the hospital and he goes through your hospital analysis and is found to be ineligible. What will you then do with that veteran? He has a health problem, he comes to the hospital, he's in the admittance area, you're reviewing his financial income, what will you do for that veteran once you determine that he is ineligible?

Dr. **Ditzler**. I think the first thing is the question of his medical need. If there is a threat to life and limb, we admit him irrespective of eligibility status regarding the means test. We would be humane in all cases.

If it is clearly a questionable area I think it will vary with the attitudes of individuals in different parts of the country. Where there is an effective social worker service, they will probably make every effort to place that man in a private sector medical facility that will care for him.

Mr. **Edgar**. Let's take that illustration you have just made—that is, the person has come into the VA hospital; he's had a preliminary examination; he has had a financial examination; he is found to be ineligible financially; it is found that his condition is not so serious that he cannot be transferred. A social worker comes in to find another medical facility in the community and they transfer him.

Is it then the intention of the VA to send that ineligible veteran a bill for services rendered in the preliminary examination in the hospital?

Dr. **Ditzler**. That is currently under discussion, sir. I do not know what the final position on that will be.

Mr. **Edgar**. According to the document that I referred to earlier, that is the intention. According to that February 15 discussion, that veteran who is ineligible, who has had a preliminary examination will, in fact, receive a bill.

Dr. **Ditzler**. I believe that we would wish to defer until we provide the proposed legislation. That is a guideline, I would take it, and whether that will or will not be so is still under discussion.

Mr. **Edgar**. What is your opinion of that? Should the VA, for that preliminary examination, send the veteran a bill?

Dr. **Ditzler**. I have no comment at this time. I think it could be used as a management tool when there is abuse of the system. If there is no abuse, I would not feel so strongly for it.

Mr. **Edgar**. Mr. Walters, in the question of third party reimbursement, is the VA prepared at this point to go into extensive negotiations with the insurance companies in coming to the same contractual relationships that other private sector hospitals have in terms of negotiating what fees they will, in fact, cover?

Mr. **Walters**. I'm not so sure I understand the question, Mr. Chairman.

Mr. **Edgar**. The question is, at present, Blue Cross and Blue Shield, using them as a specific example, in the Philadelphia area, have a contractual relationship with all the private hospitals. They do not have that contractual relationship with the VA.

If, in fact, you move to third party reimbursement fully, is the VA prepared to go into contractual negotiations with those private insurers in the same way that the private hospital system negotiates their contracts?

Mr. **Walters**. I think we would have that authority. What we have intended in the legislation that we will propose—and Miss Quandt can correct me if I'm wrong—is that we will bill the third party at the going rate in the private sector. We will bill the insurer on that basis.

Ms. **Quandt**. At the present time we have not fully developed the billing procedures that would be used for third party payment. We have proposed in the past, since the Medicare DRG rates are well accepted in the private sector, and are also being accepted by some insurance companies as an all-payer basis. For certain types of care we would bill on our DRG system, since it does have as its foundation the same New Jersey system used in the private sector.

Essentially, we would be preparing a bill and sending it to the insurance company. If we are required to negotiate, it will be in the legislative package.

Mr. **Edgar**. Let me ask you a question. Have you talked with some of the insurance companies because, as I understand it, most of them have, in fact, particularly over the last couple of years, negotiated both with hospitals and with employers in terms of what benefits will be covered. They've got copayment plans and certain amounts of copayment options. There are certain different benefit packages that are put together. The insurance companies are working with industry to try to hold down the cost of hospital care.

Is the VA prepared to get into that debate and contractual relationship with the private insurers that is now taking place with, I think, almost every private hospital?

Ms. **Quandt**. At this point in time, not having seen the legislative proposal, I cannot answer your question. I do not believe we have anticipated that type of negotiations but I think we would be authorized to do so.

Mr. **Edgar**. Let me ask you two other questions, then.

Will your legislation include a provision abrogating the contracts and the contractual relationships presently in place that say they will not fund VA-related health care?

Mr. **Walters**. Only for future contracts, and future renewals. We would not impact on existing contracts.

Mr. **Edgar**. It would abrogate the exclusionary clause.

Mr. **Walters**. That's correct, for future contracts.

Mr. **Edgar**. Finally, if after your careful study of what the private sector and private insurance companies are presently doing with hospitals in terms of contractual relationships, is the VA fully staffed to be able to do that in every region and every area of the country? Will you need additional employees in order to develop a department within the VA hospital system that will, in fact, be similar to the departments in the private sector hospitals that negotiate these third party contracts?

Mr. **Walters**. Dr. Ditzler will answer, with your permission.

Dr. **Ditzler**. A preliminary look at this idea would suggest that it would require additional people. It would also require computerization to some extent. But the net cost—the cost return, I should say—would be favorable to the Government after the second year. There would be startup costs probably in the first year, but in years the outyears there would be a net gain to the Government.

Mr. **Edgar**. Have you compared that with what is presently taking place in the private sector in terms of the ratio between your net return and the administration of the program?

Dr. **Ditzler**. Not in those terms, but I have compared it at an individual hospital level. For example, a VA hospital on one side of the street may require in its medical records room—as an example of a part of the picture—five people. The private sector hospital has 25 people. I think we can do it for half that and still have a net return to the Government.

Mr. **Edgar**. Are you prepared to collect the copayment provisions or the amount of money in terms of the first level of service? Some of them have deductibles——

Dr. **Ditzler**. That is not in our current thinking, sir.

Mr. **Edgar**. I was just wondering. I have Blue Cross and Blue Shield. Suppose I have the plan where you have to pay $100 or $200 up front. Isn't the VA going to have to be in the business of collecting that before they can provide service? Or at least after the service is provided, aren't you going to have to hand people a bill as they leave the hospital that will at least include that item in what matches their insurance?

Dr. DITZLER. That's not my understanding of it, sir. Maybe we're looking at it too simplistically, but as we see it now, it would not be nearly that complex.

Mr. EDGAR. I'm only raising these questions—and I'll stop here because I know you have other things to do and I appreciate your patience with me. But in the area of third party reimbursement, I have taken a look at it very carefully. We are going to have some very detailed hearings on it. I would hope the VA, when making its proposal, will look at all of the existing plans and what relationships they have with hospitals, what staffing requirements, what computer requirements, what copay requirement, what recovery of the costs those hospitals have to provide.

When I take my son or my wife to a hospital, I have got to go back down to the cashier before I leave. I don't think the VA is in the practice of doing that directly before they release a patient. I can envision some additional staffing requirements—they may be minimal, and they may pay for themselves, as you suggest. But I think if you're going to bring up a plan for us, those things ought to be part of the plan before we can consider it as fully addressing what you consider third party reimbursement.

I want to thank you for coming and we appreciate your willingness to respond to the questions of our members. There will be other questions that we will be submitting to you and your staff. We would appreciate an early response to those questions so that we will be able to print our hearings on a timely basis. I would hope that your response could be provided to us within 10 working days from the time you receive the questions, in that the committee will meet on March 6 to make our draft recommendations to the Committee on the Budget.

This morning we had hoped to also hear from the immediate former Chief Medical Director, Don Custis. However, over the weekend he was admitted to the Bethesda Naval Hospital for certain tests and evaluation. I am informed that the difficulties he experienced over the weekend are minor in nature. Nonetheless, they have precluded the presentation this morning of his views on the Administration's budget in reference to the Department of Medicine and Surgery.

I ask unanimous consent that Dr. Custis' testimony be included as part of the hearing record.

[The statement of Dr. Custis appears at p. 175.]

Mr. EDGAR. Let me thank you, Mr. Walters, for your patience today and for your frank answers to the questions. We will be back together on many occasions on some of the questions we have raised.

Mr. WALTERS. Thank you, Mr. Chairman.

Mr. EDGAR. We will resume our budget hearings in the morning at 9 a.m., at which time we will hear from the veterans' organizations and Dr. Paul Schafer, executive director of the National Association of VA Physicians.

This hearing now stands adjourned.

[Whereupon, at 12 noon, the committee was adjourned.]

PROPOSED VETERANS' ADMINISTRATION BUDGET FOR FISCAL YEAR 1986

THRUSDAY, FEBRUARY 21, 1985

House of Representatives,
Committee on Veterans' Affairs,
Washington, DC.

The committee met, pursuant to call, at 9:05 a.m., in room 334, Cannon House Office Building, Hon. G.V. (Sonny) Montgomery (chairman of the committee) presiding.

Present: Representatives Montgomery, Edgar, Evans, Kaptur, Mollohan, Rowland, Kanjorski, Penny, Hammerschmidt, Hendon, Molinari, and Ridge.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

The Chairman. The committee will come to order.

This morning we are continuing our hearings on the Veterans' Administration 1986 budget. Yesterday we heard from the Administrator of Veterans' Affairs and his staff. We had an opportunity to ask some very detailed questions. And I would like to thank the gentleman from Pennsylvania, Mr. Edgar, for taking the chair. It was probably one of the longest hearings we have had with the Administrator coming before this particular committee.

Last year we attempted to try to have the veterans organizations participate the same day. It was rush, rush, and did not work very well. So now we are having separate days for the veterans groups, groups that work with us, and we are very proud to have the groups here.

I would like to ask the different speakers for the different veterans groups to limit your remarks so that we can get into questions and answers. Your full statements will be put in the record.

We have a number of areas that we certainly ought to investigate and look into. The Chair will call on the national commander of the DAV, I will ask Mr. Hammerschmidt if he has any comments he would like to make.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. Hammerschmidt. Thank you, Mr. Chairman.

Yesterday the Administrator of Veterans' Affairs and his associates gave us their analyses and comments about the 1986 VA budget. Today representatives of a number of veterans organizations and the National Association of VA Physicians will give us their analyses and comments.

Our witnesses today will speak from the vantage point of long experience with VA budgets. They will also speak as representatives of consumers who are their members. But more importantly, Mr. Chairman, they will speak as advocates for those programs and benefits that have been designed and created for veterans and their dependents. In each category, experience, consumer and advocate, we have found our witnesses of today to be most helpful to our committee. Their insight, their knowledge of VA history, and their capacity to tell it like it is as they see it, gives them a most unique role. Over the years, they have been the best friends and the most vocal critics of VA's budgets. I am sure this year will be no exception.

I am totally delighted to see some old friends sitting here this morning. I want to welcome them. I look forward to hearing from them.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Hammerschmidt. They are old friends. The staff director of our committee for a number of years is a wonderful, capable person; we all love him, Oliver Meadows. We are glad to have him. Mr. Edmiston, we are glad to have you with the national commander of DAV. I see Chad across the country in Birmingham, New Orleans, and other places.

You may proceed, Mr. Colley.

STATEMENT OF CHAD COLLEY, NATIONAL COMMANDER, DISABLED AMERICAN VETERANS, ACCOMPANIED BY OLIVER E. MEADOWS, PAST NATIONAL COMMANDER, DAV; AND STEPHEN L. EDMISTON, DEPUTY NATIONAL LEGISLATIVE DIRECTOR

Mr. COLLEY. Thank you, Mr. Chairman and Mr. Hammerschmidt.

I am sure the question has probably come across your minds, what in the world is the national commander doing here at a budget hearing? I think it points out the depth of our concern, my concern personally that this is going to be a pivotal year.

The CHAIRMAN. Excuse me. For some reason, these mikes at the witness table just don't pick up as well as they should. You have to talk right into it.

Mr. COLLEY. I think that the fiscal year budget of 1986 will be pointed to as the pivotal year as it relates to veterans programs, veterans health care, and related matters.

I was somewhat disappointed in listening to a portion of the testimony yesterday. It appears that we have fallen into the trap of talking about little individual slices of the overall picture instead of looking at the budget proposal in the main.

If you look at the portion of the Federal dollar that has been expended on veterans and veterans' causes in the last 10 years, I think there has been a significant decrease. I think the Veterans' Administration should be commended for working within that budget. But I hope in our budget considerations we don't deal just with the trees; we deal with the entire forest, because there are some very grave concerns in that light.

If you look at the medical care budget, at first blush, there appears to be an increase of a substantial amount of money, $235 million. I say that from the perspective of an individual who lives in

Fort Smith, AR. It is a lot of money. When you consider what we are trying to do with that, it pales in significance.

If we were to try and provide the same amount of health care in the private sector, we would have a shortfall with this VA budget of some 3.5 percent.

The VA hospital system has a tremendous workload and is capable of doing so much. But I think that this trend of straight-line medical care funding has got to stop eventually. I think we have been able to deal with this simply from the perspective that there has not been a serious run on the VA medical system, as is likely to take place because of the aging population of our World War II veteran.

There are questions in this that, to a novice like myself, just come flying in my face. For example, I just cannot understand why the Veterans' Administration turns away, by their own admission, a quarter of a million patients, a quarter of a million veterans per year, and yet we are operating at 600 beds lower than the Congress, in its wisdom, saw fit to mandate. In fiscal year 1986 that number is going to increase to 90 beds less than what was mandated by Congress. I cannot understand how we can relate one to the other, why we can turn away patients and fail to do this. If in fact we do not have sufficient moneys to care for that many patients and fund that many beds and if we cannot hire the number of personnel to operate the medical system that Congress indicated was necessary, I am disappointed that the Administrator has not come to the Congress and said: "We've just got this shortfall and we need some help." Instead, we have been turning patients away.

If you look at the mandates of 1 percent across-the-board reduction in personnel, I am impressed with what we have done in the VA health care system. Each year we are a little bit less. I think that quite possibly the Veterans' Administration needs to be exempt from this.

The budget is predicated on a number of things which cause me some concern. The 5-percent reduction of Federal employees is one. Just what is going to happen if this doesn't happen? What portion of the VA budget is this going to be absorbed in? I am afraid that quite possibly it might be in the medical care personnel. We see that this year we are operating with some 2,000 less than was really required by the Congress.

There are a number of problems. I think we find ourselves playing a shell game. If you look at third-party reimbursement or a means test, I believe that, if you take the means test, we are not going to decrease, we are not going to make available one more hospital bed by this. We are going to move this across the board. We are going to play the shell game with veterans. It is not going to reduce the work load; it is just going to move it about somewhat.

If you take into consideration the cost of implementing these programs, I am wondering if we appreciate a single dollar savings in this regard.

It is interesting that OMB 4 years ago decided that some $300 million could be saved by third-party reimbursement. And here, 4 years later, it has been reduced to just $65 million that they anticipate. Yet, they have difficulty telling us exactly how that figure was arrived at. I dare say that if we wait 1 more year, that savings may be nonexistent even on paper.

When I came into the veterans hospital system some 3½ months after I was injured in Vietnam, and I reported to Little Rock, AR, the most available bed for me in that facility was a bed in a geriatric ward. I had no orthopedic problems or anything, no internal injuries. And that was the most available bed. I was the only one of eight patients in this room that was not diapered and fed through the nose. But it gave me a very, very vivid appreciation for the amount of care, the amount of time, and the amount of personnel it takes to care for nursing patients.

That is why I am particularly chagrined that only 4 percent of the construction budget of the VA during fiscal year 1986 is allocated to nursing home beds. I have an absolute vivid memory of that and know that we are going to need more and more of this type of care for our aging population. And I am disappointed.

I believe we get a lot of leverage out of the grants to States for construction of extended care facilities. I think that we get a lot of leverage on that. It is such a good program and yet this fiscal year 1986 budget request will be some $12.5 million less than last year. That causes me some concern.

I am also disappointed that we are seeing a trend toward contracting out. Again, at first blush it doesn't seem all that bad. We are talking about maintenance personnel or maybe even fire protection or housekeeping. Then you start talking about dietetic services. This trend is going toward an area, getting into an area that I don't think there is any question that it will affect the quality of patient care.

Congress has certainly been sensitive to this. I think again we are seeing some trends started that need to be stopped now, or we are going to look back at this budget and say, that was the year that we could have done something about it and yet we let the demise of the VA system continue.

There are a number of areas that cause concern to people out in the field that are trying to give service to veterans and disabled veterans. The idea of consolidating the regional offices is appalling.

I am also concerned that we are seeing the area of veterans staffing personnel being reduced in the Department of Veterans Benefits. They are down some 4,000 since 1980. That is a significant reduction. Further attempts to reduce that could be very devastating.

We are also concerned that the proper influence and proper attention is not being given to compensation and DIC. We support very much the proposed 4.1-percent increase. I like to deal from a sense of fairness. I feel very concerned about a great number of women who have served their husbands and their families ably over the last 30, 35, 40 years that are going to be in a very disadvantaged position on the eventual demise of their husbands.

Also, after having spent 2 years as a loan officer dealing extensively in VA loans, I am really surprised to see what is happening and what is being proposed in that program. I think too many things are being settled in the back door end of this budget. If we are going to kill programs, let's come right up front and say, we think that we can't tolerate the loan program anymore. If you are going to do something about it, don't do it in a very subtle way or allow it to be done.

The 5-percent user fee—having the experience of making those loans across the desk, I know, will be the demise of the program. To think that there is somehow going to be as many people still applying with that prohibition, in my opinion, is somewhat whistling in the dark.

Two days ago, I was with Lt. Gen. Alfred Gray, who is the commanding general of the Marine Atlantic Fleet. He told the assembled group there, about half of whom were young marines, that the battle of Iwo Jima was won not because right always wins in the end, or somehow freedom is going to win out over tyranny, not because we had millions of pounds of ordnance, and some 900 naval vessels. We won in that campaign, we won the Second World War because of people, because of men and women willing to make that sacrifice.

These same people now, if they were worthy enough to die for their country and fight for their country, our country should consider them worthy enough to secure their care. We anticipate the leadership of this committee as it relates to veterans issues is going to transcend to the entire Congress so that we can prevail, and adequate funding will be restored to this budget to care for our Nation's veterans.

Thank you.

[Statement of National Commander Chad Colley appears on p. 194.]

The CHAIRMAN. I want to thank you for a very strong, comprehensive and sincere statement.

The Chair will observe the 5-minute rule. The Chair also would like to point out that we have several other witnesses that will come to the table this morning. So, I will leave it up to you about the time you want to use. We do have a number of other witnesses from the other national organizations.

I recognize the gentleman from Arkansas.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I want to thank Chad Colley for his very candid and forthright statement. I had not intended to be too personal with this, but I have known Commander Colley for so many years. He is from my district. I just think he is doing an outstanding job, and this morning is an exhibition of his capability.

Let me ask the former national commander, Mr. Oliver Meadow, this question. Oliver, there was a means test in the 1950's. A financial paper had to be executed by each veteran applying for nonservice-connected medical care. I wonder from your long-time expertise if you would comment on your experience with that program. Would you comment on its success or lack of success?

Mr. MEADOWS. Mr. Hammerschmidt, it is interesting to hear the VA come up and ask for a means test, in light of that experience that you are referring to. Hospitals were crowded. An initiative was taken to install a means test back a good many years ago. That means test called for counselling the veteran, learning about his assets, learning about his insurance coverage, giving him a diagnosis, and ultimately telling him about how much his illness was going to cost, and then having him swear as to whether he could pay or could not pay for what appeared to be his medical bills.

This was laid out in rather elaborate detail. The history of it was this. The VA simply could never get their people to administer it. There was no enthusiasm whatsoever in the VA. On a number of occasions this committee tried to cause the VA to take a more aggressive attitude about that means test. They simply refused to administer it. They never really tried, because it was complicated and onerous and difficult.

Finally, year after year, the spokesman of the Veterans' Administration came up here on bended knee and asked us to please get rid of it. Finally, after 3 or 4 subsequent years and subsequent requests, we did so.

Mr. HAMMERSCHMIDT. Thank you.

Mr. Commander, what would the position of the DAV be if Congress attempted to put a freeze on all COLA's, including Social Security?

Mr. COLLEY. Mr. Hammerschmidt, one of the things that veterans, I believe, down deep want, is a budget that we can support. We don't want to be against everything. We fought for our country. We are patriots in the truest sense of the word. We want a budget that we can support actively. If that is made across the board, I believe the veterans across this country would be more than willing to do their part. We want to see it equitable. We want to do our share.

There was an article in yesterday's New York Times that alluded to the fact that the implementation of an across-the-board freeze could move as many as one-half million people under the poverty level. So, it is something that should not be done without careful consideration. But I really believe that the veterans want to do their part. If that is part of it, I think we would be willing to support that.

Mr. HAMMERSCHMIDT. Thank you.

From your field reports, do you feel that there are very many affluent veterans receiving non-service-connected care?

Mr. COLLEY. I don't think that I have ever seen what could be called affluent veterans waiting in these waiting areas, for clinics, or admission to the hospital. If they have got an alternative means of treatment, more than likely they are going to exercise that before they will go through the difficult and arduous process of receiving treatment.

Mr. HAMMERSCHMIDT. I believe my time is almost up, but I do want to compliment you for your statement about doing your share. The DAV and other veterans organizations led the way on that subject last time. It is about as patriotic a position as you could take. We appreciate it very much. Thank you.

The CHAIRMAN. Before I recognize Mr. Edgar, let the chair ask unanimous consent that a statement from Miss Susan Jacobs, Chief, Veterans Affairs Branch, Veterans and Labor Division of the OMB, be put in the record.

[The statement of Miss Jacobs appears on p. 209.]

The CHAIRMAN. Mr. Edgar can follow up on this, this document indicates an agreement has been reached between OMB and the VA in the treatment of veterans over age 65 who do not meet the means test. It says these veterans would first be required to seek care available to them through their Medicare coverage. We certainly don't want to do that. We want them to be treated in VA if beds are available.

After reading this document a little more carefully, it looks like we had better not act until we have a few more facts. There might be more problems than we had first thought.

Mr. MEADOWS. The Veterans' Administration will certainly have to do something different from what they have been able to do in the past to enforce some sort of a simple workable means test that will be viewed as fair by veterans. This complicated buy-down arrangement that OMB has advanced certainly does not meet that test.

In the absence of a fairly simple, fair, workable means test, it would be better to retain the 65 policy that the committee now has. But we don't know exactly what they are coming up with. We only have one or two work papers that we have been able to obtain. But it is a complicated buy-down deal where the veteran maybe can get in the VA hospital after he spends some of his own money. This kind of a situation, at least recalling their last attempt to administer a means test, I don't think they can make it work.

The CHAIRMAN. Mr. Edgar.

Mr. EDGAR. Thank you, Mr. Chairman. Mr. Chairman, I want to commend you for putting in the record the statement which I referred to yesterday in my questioning to Harry Walters. I think it is going to be a horrendous system as people have to buy down on their Medicare benefits before they can qualify for their veterans benefits.

I would like to ask unanimous consent to include in the record another document at this time, also from the White House. In a briefing for women in housing and finance on February 15, 1985, it indicates who was part of that particular briefing. I would like to insert page 15 of that briefing into the record at this time.

The CHAIRMAN. Without objection, so ordered.[1]

Mr. EDGAR. I would like to refer to it and get your reaction. On page 15 it says, seek other means of support before using taxpayer dollars to fund veterans health care. And it lays out in the first point new policies to contain VA health care system costs and reduce eligibility are imperative, the document states. And then it lists four or five points, including the fact that if nothing is done, the VA estimates that annual operations and construction costs will be as high as $37 billion annually to care for these individuals. That is referring to the number of age 65 and older veterans who will be coming into the system.

The part of this page that troubles me the most is the last point. Let me refer to it, read it carefully and let you react. It says, these changes are expected to reduce in-patient utilization from current levels, lowering system operating and construction costs by more than $7.5 billion over the next 5 years.

Mr. COLLEY. That would effectively eliminate the system.

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[1] See p. 217.

Mr. EDGAR. It is troubling to me that the number of $7.5 billion over 5 years does not seem to me to correspond with the administrator's testimony yesterday, where he talked about this not being a step backward but in fact them being able to continue basic service to non-service-connected veterans, to the need veterans, and to most of the people that are provided for now.

Does that figure sound a bit high to you?

Mr. COLLEY. Considerably too high.

Mr. EDGAR. Mr. Meadows, do you want to respond to that?

Mr. MEADOWS. Mr. Edgar, this brings out in the open what I think is the central problem that the commander alluded to. The problem we have is not, as the commander said, another $200 million, some little minor change in this year's budget. The problem is the war of attrition that we have been fighting with OMB for the last 15 or 20 years. As staff director of this committee, I have accompanied the chairmen of this committee, Olin Teague, William Jennings Bryan Dorn, Ray Roberts, and this chairman here, to the floor nine times to try to seek restoration of funds that were being cut back that would reduce the VA FTEE 2,000 or 3,000 or 4,000 a year. And we won, the veterans won, this committee won every time. But it was like a broken record. Each year it's the same thing, some scheme that lowers the FTEE 2,000, 3,000, 4,000, by some devious manner, and this committee rallying to try to save some of that and then fighting the subsequent battle to try to make the OMB allow VA to use the funds after they have been restored.

I think the bedrock of all our problem is that we have a deep paranoia about OMB and its schemes to simply remove or greatly reduce or greatly circumscribe the VA medical system. And that is the real problem as the commander said, not some little figures, $200 million here, $200 million here, on this year's budget. We believe that the OMB is determined to see a major reorientation of this program and to reduce it very substantially in size and change its mission. That is the thing that disturbs us greatly.

Mr. EDGAR. There is one other thing that disturbs me in this particular document. Up in the earlier portion, where it talks about increasing budgets by $37 billion if we do nothing, in the VA's own report entitled "Caring for American Veterans," they estimated the cost at something between $18 and $22 billion if nothing was done, that is, the influx of aging veterans. I think it is strange that as early as September of this year, when they released the aging report, that they would say $18 to $22 billion, and now in briefings before the White House they are talking $37 billion. I hope that we can get some clarification from the White House, from OMB, and from the Veterans' Administration as to what the disparity is in terms of these numbers and whether or not they are simply guesses.

Thank you for your response.

The CHAIRMAN. Thank you, Mr. Edgar. The Chair recognize the gentleman from New York.

Mr. MOLINARI. Thank you, Mr. Chairman. I just have one question. Well, actually, I was going to pose two.

First, Mr. Colley, I was going to ask you if you ever considered running for Congress. And then, after hearing Mr. Hammerschmidt's opening remarks, I thought I better not ask that question.

One question though that I would like to ask is this. In my congressional district we seem to—I am a member of just about every veterans' organization. We seem to have a great deal of difficulty in getting veterans to join the various veterans' organizations. I, myself, have attempted to recruit, with very limited success, Vietnam veterans. I would like to get your view on why that is and what could be done to help that situation.

Mr. COLLEY. I think that it is a very complex problem. There are probably many different reasons. I, like you, have involved myself in it to some degree of limited success. I think that the fact, if you look at this budget as proposed and what it is doing to the system, I think a lot of Vietnam veterans are cynical about just how strong the depth of the commitment of the Nation is. We say we want to welcome them back. We want to have parades and give them this recognition that now we feel that they are due, on one hand. But on the other hand, we are talking about the demise of the system that our country created, our government created to care for them. This cynicism, I think, inhibits their willingness to associate and participate in what World War II and Korean veterans found a natural extension of their service.

Because of the atmosphere of the time when many of the veterans returned there was an unwillingness to identify themselves with the initiative of our country as it relates to Vietnam. And this somewhat has carried over. The cynicism that they feel because we are saying, yes, we're going to care for you, on one hand, and then they see what is happening to the VA system on the other. It makes them say, yes, my worst suspicions were confirmed; I really don't have any desire to have involvement.

Mr. MOLINARI. Thank you. I have no further questions.

The CHAIRMAN. Thank you. If you like Washington and wanted a job, I think Mr. Hammerschmidt would find you one.

Mr. COLLEY. I appreciate that. You know, Abe Lemmons, the past basketball coach from Texas, used to say the best thing about coming to Fayetteville was he got to go home. That may well be the best thing about Washington; I do get to go home.

The CHAIRMAN. Lane Evans of Illinois.

Mr. EVANS. Thank you, Mr. Chairman.

I really don't have any comments or questions. I just appreciate your making the personal commitment and making a comprehensive statement. I do have one comment on the statement about the younger marines. I wonder what signal we are sending to those young marines, what kind of morale they are going to have.

Mr. COLLEY. I am sure that was in the back of their mind. The point he was trying to make was people really make the difference. That is what it is all about. Those men, it took a lot of courage and a lot of dignity on their part to be willing to make what was a very tremendous sacrifice on their part. And for them to do that, his statement was our country is worthy, should be worthy enough to care for them in this day and time. That certainly is the position of the DAV, and I know the members of this committee also.

The CHAIRMAN. I might point out to other witnesses this morning the order that we have taken them is the order that the testimony came in to the committee. The first testimony was from the DAV. So, next time, if you want to get up and start early, get your testimony in early.

I would like to welcome a new member of the committee, Bill Hendon of North Carolina.

Mr. HENDON. Thank you, Mr. Chairman. I have no questions, other than to compliment the witnesses for their fine service to the country and the absolutely fine job they are now doing. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Rowland.

Mr. ROWLAND Thank you, Mr. Chairman.

Commander Colley, I compliment you on a very clear and concise statement, easily understandable. There are a couple of things that I would like to comment on and ask you a question. You confirmed what I have heard in my district in town meetings. People will accept a freeze across the board to address the budget deficit problem that we have. I found the veteran would be very pleased to do that if it were across the board, but not pick out some particular group and use them to address the budget deficit problem. I am glad to hear you say that veterans that you know would be happy to do that, too.

I want to ask just a question about the means test. I have asked for some information from the VA hospital in my district about how many affluent veterans are being treated in that hospital and would a means test really make much difference. I have not gotten that information back yet. Would you find a means test to be particularly damaging to the Vietnam veterans in view of what Mr. Molinari said about the inability to get Vietnam veterans involved in veterans organizations, the feeling that they have about that? Do you think that the means test would be even further damaging in that respect?

Mr. COLLEY. I think, Mr. Rowland, that in this particular instance this is going to be an equal opportunity disadvantage. It is going to affect not only Vietnam veterans. It is going to affect veterans of both the Korean War and World War II as well. No one is going to be exempt from this.

I have great difficulty with this. I think, as I said, we are going to play a shell game. I believe that, if we spotlight this group, that we really say if you make less than $15,000, you are entitled, even if you have got insurance or whatever, if we spotlight this group, I think it may work to the disadvantage of the VA. I think a lot of people may say, well, wait a minute, I'm in that category. I only make, whatever, and I know that and I can prove it, there's no doubt.

I think it may well be to the disadvantage of the VA in this regard, simply because there are a number of veterans out there that will hit that criteria without any difficulty whatsoever.

Mr. ROWLAND Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Rowland.

Mr. Mollohan of West Virginia?

Mr. MOLLOHAN. No questions, Mr. Chairman.

The CHAIRMAN. Thank you very much. We appreciate you being here this morning.

Our next witness is Dr. Paul Schafer, executive director of the National Association of VA Physicians. I would like to welcome Dr. Schafer. He is always eloquent. We are glad to hear you.

STATEMENT OF PAUL W. SCHAFER, M.D., EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF VA PHYSICIANS

Dr. SCHAFER. Mr. Chairman and members of the committee, as you know, I am employed full time by the Veterans' Administration and serve as Chief of Chest Surgery at the VA Medical Center here in Washington, DC. In addition to patient care, I carry my fair share of administrative burdens. I am actively involved in basic biological research. I teach undergraduate medical students and postgraduate house officers. I am academically identified as professor of surgery, Georgetown University.

Today I appear before you in a strictly unofficial capacity in respect to the agency but as a spokesperson for the National Association of VA Physicians. I serve that organization as its executive director. We are most appreciative of this opportunity to express the grave concern for the fate of the Veterans' Medical Program, which I know we share with you. We will lend our support to any and all efforts to defeat those who now are obvious in their attempt to destroy this program.

For some outside this room who may feel this too harsh a charge, their attention should be directed to the recent brayings of that ex-divinity school student, excused from military service during the Vietnam war, the present Director of the administration's Office of Management and Budget. Not long ago, David Stockman had the effrontery to attack medical benefits for veterans, and I quote: "who do not even have a hangnail to show for their harrowing experiences in uniform." In recent days he has added active duty personnel to his hit list charging that the Armed Forces care more about their retirement program than about the Nation's security.

It must surely strain the conscience of those who testify in support of this administration's proposed budget for the Veterans Medical Program. To start off, the proposed real inflation-adjusted dollars in this budget represent a decrease in the funding level which has been without real increase for a decade. This in spite of the agency's own recently published forecast that the needs of our veterans of World War II and of Korea are peaking and those of our Vietnam veterans are on the rise. Unmentioned is the prospect that more than actuarial statistics may be involved. The Nation's concerns in Central America, Afghanistan, South Africa, the Middle East, and elsewhere have the potential to produce casualties, care for whom would immediately become an obligation of VA personnel and facilities. It is irrational to reduce beds and health care personnel in the face of a documented workload increase and the potential need to serve even more veterans.

A prior administration's representatives exhorted us to like being lean and hungry; the slogan was "less is better." This one doesn't even bother. It just proposes fewer beds, fewer staff, less construction, denied care, and a nonviable Veterans Medical Program level which in 1990 would have 14,000 fewer beds and over 22,000 fewer staff. Its fantasies include a means test, a third-party bonanza, and an attitude about the burgeoning numbers of veterans over the age of 65 years which might just as well be expressed by Marie Antoinette's callous observation, "Let them eat cake."

But, Mr. Chairman, aside from dollars in the equation, what of health care personnel morale. This administration and its minions propose a 5-percent pay cut, a Grace Commission-recommended grade reduction schedule, a minimum retirement age increase from 55 to 65 with increased penalties for early retirement, decreased cost-of-living adjustment, high 5- rather than high 3-year basis for annuity calculations, elimination of unused sick leave for retirement credit, decreased survivor benefits, and implementation of a health care voucher plan. Almost as if to rub salt in the wound, the Office of Personnel Management has come up with a novel disincentive proposal which defied description. This latest gem is the recommendation that Federal agencies hire only temporary employees. The proposal is couched in terms of improved efficiency but in fact it is nothing less than an instrument for greater control of the Federal civil service and particularly for shortsighted cost savings.

Temporaries can be fired without notice. Their term of employment is proposed for extension from 2 to 4 years or more. They get no health insurance and few other benefits. Thus OPM follows the lead of HUD in its publication 0003744, which recommends to cities that they turn public services over to private entrepreneurs since they can hire more temporaries, who can be made to work longer hours, have less leave time, and can be fired at will. The Government would get what it pays for, namely a less motivated and a less competent work force. This is no way to run a railroad.

OPM head Donald--the not-so—Devine's other novel entry into the privatization sweepstakes race has to compete with such formidable opposition as private-for-profit operation of airports, waterways, satellites, prisons, et cetera. Devine is now trying to justify the administration's proposed Federal pay cut on the basis of comparing the quit rate of Federal workers to that of workers in the private sector. This statistical prostitution makes even the Grace Commission proposals appear falsely to have a modicum of credibility.

Though they don't come out and say it, what this administration is up to is no mystery. It is explicitly set forth in the recommendations of the influential Heritage Foundation, which read as follows:

> Congress should eliminate all pensions for veterans and survivors of veterans which are not compensable as service-connected. It is recommended that the present VA health care system be dismantled. VA hospitals and other facilities should be turned over to local governments or private groups where their continued operation is economically viable.

This privatization concept is in many ways reflected in the administration's proposed budget and should be denounced lest it come to full flower next year or the year after. Inexorably increasing influence are already at work in subtle and seemingly complex ways. Among these we can identify the use of diagnosis related groups, DRG's, as the basis for Medicare payments to hospitals in the private sector. An eligible patient diagnosed within a given DRG will have his or her hospitalization paid for out of Medicare funds at a specific dollar amount irrespective of how much or how little care was rendered or how long the patient stayed in the hospital. This will also increasingly be recognized as a basis for paying insurance claims. No matter how the DRG concept is embellished or what payment formula adjustments are made, the fact is that the level of payment is ultimately determined by one index, namely length of stay in the hospital, a far too simplistic indicator of complex health care needs, particularly those of patients in their advancing years.

We now see the predictable and obvious result. Many private hospitals will not now admit certain patients whose needs can be foreseen to require extended length of stay. If the patient gets in and is later found to require extended hospitalization, enormous pressure is generated to get them out to someplace else, if possible a VA hospital. This highly questionable process will surely become the rule rather than the current common exception as health care becomes more of a mega-industry.

On the concern about hangnails, take it from one whose practice consists solely of veterans with life-threatening illness and no place else to turn for help, in my line of work there are no hangnails.

Mr. Chairman, this concludes my testimony, which was prepared and sent to the committee Friday last. Late that same day I received distressing information which will impact the agency's budget in many substantial ways. Yesterday VA Administrator Walters unveiled to you the existence of his modernization plan which is in fact a logical extension of the DM&S Decentralized Hospital Computer Program. Just a short time ago, you and I separately warned the agency to take all necessary measures to prevent further key personnel losses such as we experienced with the departure of Martin Ivers, the agency's most competent data processing administrator. The information I received last Friday was that George Timson, the creator of the VA file manager, the Heart of the whole DM&S DHCP system, tendered his resignation effective March 1, 1985.

I know further that we are slated soon to lose most of the remainder of the key figures in the underground railroad. We are thus in a crisis situation, both in respect to computerization within the Veterans' Administration, but also in reference to promising sharing relationships with medical services in the Department of Defense.

I feel it necessary that emergency action should be taken. We stand ready with ideas and with support to help turn this around.

Thank you for your indulgence.

[The prepared statement of Dr. Schafer appears on p. 218.]

The CHAIRMAN. Thank you, Dr. Schafer, for very outstanding testimony. You have always been one of our best witnesses. You certainly call a spade a spade.

You know, the more testimony I hear from the witnesses and from the Administrator the more, I am concerned. We are looking for ways to slow down Government spending in veterans areas if we can cooperate and other committees do the same thing. About the only way anything might be done is that if you just freeze everything, the COLA's for everybody, Social Security, everybody, veterans, military, the whole ball of wax. But to start whittling away at the medical care of the veterans and what has been recommended from the administration, I am concerned about it.

I am talking a freeze for 1 year. These are just thoughts. None of us are locked in. I am not locked in to just what I said. It is something we are going to have to look at if we are really sincere about slowing down Government spending.

I have been a little worried. I had not heard this before, but when I was in my home State just last week I had one doctor confront me. I had two other doctors from private enterprise who have their own practices talk to me. They, in effect, said the veterans medical system was not any good and that it should be done away with. In the next breath they said that they were trained at the veterans hospitals, and that is why they knew something about it.

Why are these doctors saying that now? What is the problem? I never heard this before.

Dr. SCHAFER. Well, I've heard it before. And I am not sure I know exactly what the answer to your question is. I can only speak for those experiences I have had. I come from a background which is the private sector and the academic aspect of medicine. I believe I had exposure to the best that was available out in those two very critical areas of our whole health care society.

I came from the University of Kansas as professor and chairman of surgery to the Walter Reed Army Hospital, where I was Chief of Thoracic and Cardiovascular Surgery. The comparison of the care as between the two places tipped in favor of what we were able to do at Walter Reed. We gave our patients far better care than we were able to give in the private sector in an ideal academic setting. There came a hiatus in my surgical experience, but when it came time to come back into my community, which is medicine and particularly surgery, I remembered that Army experience. I opted to come to the Veterans' Administration rather than to be in the position of delivering care in the private sector with all the constraints that I knew existed.

I have been associated as Chief of Thoracic Surgery with the Veterans' Administration Medical Center here in Washington, DC, now for 21 years. You will forgive me, this is, I believe, an accurate statement. A veteran coming to our hospital with one of the serious life-threatening diseases that I treat, I believe gets as good as and, I think, better care than he would get in any other hospital in this metropolitan area. And I take no back seat to anybody in respect to that aspect of what it is we do.

Now, I can't speak for places where I have not had that kind of familiarity. But I do know that in respect to other services at our hospital, our veterans get extremely good care.

The CHAIRMAN. Well, I feel the same way you do. I would get out of this job if I didn't think we were doing good for the veterans. I talked to the dean of one of the medical schools in Mississippi. He practices like you do, both at a veterans' hospital and he also teaches. He gave me a good answer. He said, all I can tell you is that a number of Mississippians are living longer who could not because of their incomes, gotten medical care. With the care they received in VA hospital they are living in more comfort because of the veterans hospitals. That was a good enough answer for me.

I was just surprised. This doctor hit me at a public forum only last week. It was rather surprising to take that strong a position.

Thank you. You certainly helped to answer my question.

We have five other witnesses. I am sorry I took this much time. The Chair will recognize any member who would like to have a comment.

Mr. Hammerschmidt?

Mr. **Hammerschmidt**. Mr. Chairman, I want to thank Dr. Schafer. We know of his great professional skill both as a teacher and a practitioner in thoracic and cardiovascular surgery. We appreciate him being here this morning.

I did want to comment on your testimony, Dr. Schafer. In the part where you set out the Heritage Foundation recommendations, which are rather frightening. It is my impression that the administration has not adopted in any shape, form, or fashion the recommendations from the Heritage Foundation that you quote here. And obviously this committee does not support them either. We have seen this philosophy come up to the Hill in one form or another for 16 or 18 years, and it does seem frightening, but I do not think the administration has adopted any of those particular recommendations.

The other comment I would make is that, as you probably already know, a number of your comments directed to the Office of Personnel Management are not under the jurisdiction of this particular committee. It would come under the Civil Service and Post Office Committee.

I just wanted to make those comments for the record. Thank you very much.

The **Chairman**. Mr. Edgar?

Mr. **Edgar**. Thank you, Mr. Chairman. Mr. Schafer, I respect your statement and appreciate your frankness. I just want to make sure that you are not prejudiced against all ex-divinity students. I just wanted to clarify that.

Also, I was impressed with the fact that you found out what Donald Devine's middle name really was.

Let me ask you one question. Can you describe the morale within the VA in terms of its staff and personnel that you deal with?

Dr. **Schafer**. It remains good, Mr. Edgar, but it is at a fragile point. I am frequently asked questions and I have to answer them. I don't really believe they build morale. I am sorry to have to give those answers. The reason why I put in the morale part of my testimony here, knowing that, of course, it is not absolutely related to the budgetary aspect, is that they are almost inseparable. The people who come to me concerned and obviously with morale that is at a very fragile point, these are the questions they ask. They are much more apt to ask me a question about what are the prospects of changing the retirement program rather than what of the prospect of the exact allocation of beds for 1988.

The things that they talk about are the things that impinge upon them so directly, and some of these people are in a state of very considerable hazard if some of these recommendations that are floating around would actually become fact.

Mr. **Edgar**. Thank you very much. I appreciate your statement and look forward to hearing from you in the future.

The CHAIRMAN. The gentleman from New York.

Mr. MOLINARI. For what it's worth, I heard on the radio coming in to the hearing this morning that Mr. Stockman had some kind of a dizzy spell during the night and checked into a hospital himself this morning. I hope it wasn't related to this hearing.

The CHAIRMAN. As far as I know, he didn't check into a military hospital or a veterans hospital.

Mr. MOLINARI. I must say, picking up where the chairman left off, I have heard similar complaints in my district, and of course it concerns us if in fact we are dedicated to ensure that the veterans are going to veterans hospitals and receiving good medical care. How does this committee evaluate or make a determination that in fact the medical care that a veteran is receiving at a VA hospital is at least equivalent to that they are receiving in the private hospital sector?

Dr. SCHAFER. If I understand your comment and question, I believe it has two parts. Let me address the one first. It has to do with what clearly is a very, very bad public relations image among folks. There is no question, as I said in response to the first question, I get those same complaints. I never get in a taxicab in this city and identify who I am, where I want to go or from whence I have come but what I get into a discussion with the cab driver, often a veteran. And the image is bad.

I think the Veterans' Administration and those of us who are concerned about it, concerned about the veterans medical program have done a terribly poor job in getting out the word of what very, very good work we do do.

Now, as to the second part of your question, how do we get at the hard facts, particularly how do we get them out and make them known. I sit on so many committees in our hospital where we are exorcising ourselves all the time to assess the quality of the experience that we are giving to our veterans. I can tell you we do everything within our power to pick up the least little thing, that is obviously something that could be done better; and then we try to correct that. That information is all available. We have it in what we call formally our quality assurance programs. Now, in the quality assurance programs we have a prohibition on how much of that information can be made public. That exists, I believe, in law and, I think, with implementing regulations.

If we could get access to the quality assurance data that exists in every one of our medical centers and could make that public, could let people see how diligently we look for areas that we can improve, I think it would make a word of difference. It is true what I have said. The documentation is that. The trick is to get it out.

Mr. HAMMERSCHMIDT. Would the gentleman yield?

Mr. MOLINARI. I would be glad to.

Mr. HAMMERSCHMIDT. I just want to make a comment along those lines. In Arkansas many of the top doctors serve in both the VA and private sector. Many, even most of them were trained in affiliated medical centers. There are 103 of these kinds of affiliations across the country. If the VA system is bad, then the private sector is bad. They are so interdependent, one on the other. It cuts across both the private sector and the VA system.

In Arkansas at least, the VA could not operate without the medical schools. And the medical schools could not operate without the VA. And I am sure that is true in almost all such affiliations across this country.

Thank you.

Mr. MOLINARI. No further question, thank you.

The CHAIRMAN. Thank you, Dr. Schafer, for this very fine testimony. You can go back to operating now. Thank you very much.

Dr. SCHAFER. Thank you, sir.

The CHAIRMAN. I would like to call the AMVETS representative, Colonel Passamaneck, who is a friend of ours. He is legislative director. Your full statement will be inserted into the record. We are glad to have you here.

STATEMENT OF LT. COL. DAVID J. PASSAMANECK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Colonel PASSAMANECK. Thank you, Mr. Chairman.

Last year in AMVETS testimony before this committee, we stated:

> The current practice of this administration of grouping veterans programs with other so-called middle-class entitlements is not only insulting to veterans, but completely inconsistent with the President's obvious sincere concern for the condition of our defense posture. In this connection, the handwriting is on the wall in this budget, with the ominous warning that in order to minimize the need for future tax increases, veterans programs will be subject to intensive scrutiny.

That was last year. We are now seeing the results of the intensive scrutiny. The most outstanding characteristic of the 1986 VA budget, which is approximately $123 million less than last year, is that it represents the first real turnaround in a policy of gradual but steadily improving entitlements and services for veterans and their dependents since the depression of the 1930's.

The apparent solution, as far as the administration is concerned, for the impending 40 percent increase in veterans 65 and over by the year 2000 with the attendant need for intense development of geriatric care systems is to cut the heart out of the VA Medical Program with the immediate objective of removing all but service-connected disabled from the rolls of those eligible for VA medical care and ultimately to provide such care for combat and instrumentality of war disabilities only. Make no mistake about it, Mr. Chairman and gentlemen, this is the stated long-range objective of the Grace Commission.

In addition to recommending a cut of over $150 million in construction funding, mostly for improvements to inadequate medical facilities, on the inspiration of Mr. David A. Stockman, the Director of OMB, the administration is seeking legislation to cancel the current space available entitlement to medical care for veterans 65 and over, regardless of economic need, and require all non-service connected veterans who were not POW's and who are not on the pension rolls or suffering from agent orange or radiation conditions to pass what amounts to a pauper's test in order to receive medical care from the VA.

This same Mr. Stockman, who in his approach to the budget has demonstrated unmitigated contempt for veterans and retired military, is the young man who enrolled in Harvard Divinity School during the Vietnam war in order to avoid military service.

When confronted at the VA's briefing on the budget with serious questions posed by AMVETS and other veterans groups regarding the cost of implementing the suggested means test, the leadership of the VA shrugged their shoulders in bewilderment but made it clear that the cost of driving millions of elderly veterans from VA facilities would indeed be tremendous. Of course, no mention was made of the veterans who, discouraged by the abuse and redtape which would be involved in enforcing the means test, simply would not attempt to seek necessary but preventive treatment to stay the onset of degenerative geriatric conditions.

To further impair the ability of veterans to secure adequate medical health care, the budget also calls for intensive third party collection from insurers with a resulting sharp increase in premiums and restriction in coverage.

The administration also seeks to drive millions of veterans from the ranks of homeowners by increasing the loan guarantee funding fee from 1 to 5 percent. This will effectively eliminate the no-down-payment purchase of homes by veterans or drastically increase the rates of foreclosure.

The plans for the Department of Veterans Benefits call for slashing over $4 million and about 700 employees. Also, if the budget cutters have their way, the regional offices as we know them will be eliminated, leaving in their places some 59 compact offices with the adjudication, loan guarantee, rating, and other administrative functions removed to three regional centers.

In other words, the bureaucracy will be made even more impersonal with the attendant delays, uncertainties and hardships impacting on the veterans. Hundreds of employees will be removed from most States. Those who do not wish to be uprooted will lose their jobs.

The request appropriation for this consolidation for 1986 is $25 million, but the cost may well be six times that amount.

Although the administration proposed a 4.1 percent cost-of-living increase for compensation and pension, at the same time it seeks to completely undermine the basic quality of VA compensation and pension by subjecting them to the tender mercies of income taxation. The same absurd proposal has been suggested for military disability retirement pay, even for those currently entitled to tax-free pay. We commend Administrator Harry Walters for his courageous opposition to this monstrous scheme. We also deeply appreciate the chairman's and Mr. Hammerschmidt's strong rebuttal on the matter.

AMVETS enthusiastically supports the President's policies regarding national defense, foreign affairs, and the stimulation of the private economy through lower taxes and less government spending in areas where Government has no business intruding. National defense, most definitely, including the cost of military personnel, active and retired and the cost of veterans programs is one area where Government does have a basic and historic responsibility. When we cut expenditures, the last thing we should do is cut them in this area.

Thank you.

[The statement of Colonel Passamaneck appears on p. 222.]

The **Chairman**. I thank you, Colonel, for that very strong statement. I would like to commend you as one of the first ones in AMVETS who came on board working on the GI education bill, which we did implement. I thank a number of people in this room for their help. I would like to point out that not only did it improve the recruitment and retention of the military, we have had a lot of favorable comment from the military by extending the delimiting date on the GI bill. We are going to keep some of these persons, key persons that we need in the military from getting out. We received several complimentary letters from the service people. So, the thing has worked pretty well. I want to thank you.

The Chair will recognize any member that might have a comment or question. Mr. Hammerschmidt?

Mr. **Hammerschmidt**. Thank you very much for your strong statement.

What will your position be if Congress attempted to put a freeze on all COLA's including Social Security?

Colonel **Passamaneck**. The position of the organization of AMVETS is that the concept, the idea of treating all transfer payment programs, entitlement programs, whatever you wish to describe them, as if they were equal is a very serious moral fault, in our thinking, concerning all of these matters. We can argue, Mr. Hammerschmidt, legitimately about whether $200,000 should be added or subtracted or whether a program is efficient or inefficient. And I concede that many VA programs probably could be made more efficient. I mean, that is not really the argument.

We must start, however, as far as we are concerned from the basic premise that veterans entitlements, the entitlements of military people, active and retired, the cost of national defense, and so forth, and all these matters that are related to fighting wars is something to be treated differently, special, above, and in a first priority over everything else, including Social Security. Therefore, we would be basically opposed to any idea that attempts to treat these matters or these programs as if they were the same.

In other words, sir, when you get through freezing everybody else and you still need some money, then maybe we'll sit down and talk to you about freezing veterans' entitlements.

Mr. **Hammerschmidt**. Thank you for letting us know AMVETS' position on that.

You indicated that if third-party reimbursement were instituted, health insurance premiums would sharply increase. GAO has indicated the increase would be small. I wonder if you would care to elaborate on your testimony.

Colonel **Passamaneck**. Well, we really don't have hard figures. That is our perception, that they will go up. It is a matter of supply and demand thinking, sir. Other than that, it is really nothing more than a conclusion, an idea.

Mr. **Hammerschmidt**. If you would care to expand on that further for the record, we would appreciate it.

Colonel **Passamaneck**. I will endeavor to do so. I think it is a very interesting subject. Most of the veterans organizations, as I know, have objected to this proposal but have not been all that specific in saying what the actual impact would be. Perhaps we are included in that category. I will endeavor to address it more specifically for you, sir.

Mr. HAMMERSCHMIDT. I just have one other comment. I notice that you mentioned in your testimony a proposal to tax compensation. Of course, that was run by the administration, by the Treasury Department. The administration turned it down. We are very grateful for that.

Colonel PASSAMANECK. Yes. Thank you.

The CHAIRMAN. If there are no other questions, I appreciate our witness being here this morning.

The Chair would like to recognize Mr. Ridge from Pennsylvania.

Mr. RIDGE. Thank you, Mr. Chairman. I have just one quick question. I recognize we have many other witnesses that we want to hear.

Sir, in response to Congressman Hammerschmidt's question you said you had an opinion, a perception. If you have some hard data, if you have done any comparative studies to demonstrate that in fact with the anticipated increase in the number of veterans over 65 by the year 2000, with the increasing pressure on the VA system to meet their needs, if in fact the savings suggested by the Grace Commission and the administration are real or imagined, we would like to have it. The VA traditionally has done more with less. They have provided good medical treatment.

Do we end up by reducing funds available to the VA and putting a lot of these people into private care facilities? We have got some attempts there to control costs. But are the savings real or imagined based on projections of the administration that you have seen? Can you direct me to such a study? Has anybody sat down and said, Look, you are going to close these facilities where we run a much tighter ship than many of the private hospitals do, certainly a much tighter ship than the for-profit hospitals. And you are going to take these veterans away from these facilities that have traditionally done more with less and put them in a private care facility.

Will we save any money on that? If they are being taken care of through the VA, are we saving money in the Medicare system that way? Are there any private studies that you could direct me to that reach that conclusion?

Colonel PASSAMANECK. I couldn't address my remarks to any specific studies. I am not conscious of any. I know that there has been a great deal of discussion, at least concerning this budget, along those lines. In the full text of my testimony we point out that actually, instead of saving money, the cost per capita of providing the same amount of service to veterans in need of it would probably go up about 10 percent if we follow the recommendations of the Grace Commission; that is, to mainstream and to put the non-service-connected veterans out of the VA hospitals.

Now, of course, there is no guarantee that the non-service-connected veteran or even the service-connected veterans to some extent will get the same degree of care under these proposals in the long run that he is now. Then, of course, it would save a lot of money for the Government, because we just wouldn't treat these people.

Mr. Ridge. Again, I am not saying that I agree. I am not saying necessarily that we should or should not. I just think that it would be interesting to learn if you ever run across a study similar in nature to that, taking a look at the medical history of the veterans being treated over the past 20 years and just projecting the burden on the VA system based on that previous experience. I sense that many of the savings would certainly be illusory. Most of my veterans would prefer—I had a father-in-law who is now deceased, but he was a career serviceman and veteran. He had the option of going to any facility he wanted to. He chose to always be treated in and in fact he died in a VA hospital. He was very comfortable there.

Again, as Dr. Schafer pointed out in his testimony, it was not a free service. It was prepaid by 25 years in the service of his country.

I appreciate your testimony.

Colonel Passamaneck. Thank you.

The Chairman. Thank you very much, sir.

Our next witnesses are from the Veterans of Foreign Wars. Donald Schwab is director, national legislative service. Frederico Juarbe is director, national veterans service. Cooper T. Holt is executive director of the Washington office.

You have been around here about as long as we have.

Mr. Holt. In times of trouble, sir, I'll always be here.

The Chairman. The Tennessee flash.

You may proceed however you like.

STATEMENT OF DONALD SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS, ACCOMPANIED BY FREDERICO JUARBE, DIRECTOR, NATIONAL VETERANS SERVICE, AND COOPER T. HOLT, EXECUTIVE DIRECTOR, WASHINGTON OFFICE

Mr. Schwab. Thank you, Mr. Chairman. The gentleman on my right, of course, is Fred Juarbe, the director of our national veterans service.

Thank you for the privilege of appearing before this distinguished committee.

Mr. Chairman, we of the VFW view the proposed budget of the Veterans' Administration for the fiscal year 1986 as an unprecedented assault on the Veterans' Administration, its hospital and medical care system, sugar coated by a proposed 4.1-percent increase in compensation and pension effective December 1, 1985. We believe veterans have made a very substantial contribution to deficit reduction. In my prepared text we quote the article by the chairman published in our VFW magazine in the February edition. It outlines the contribution that veterans have made to deficit reduction.

The VFW, Mr. Chairman, has historically held that any veterans who served during periods of war and hostility and are in need of medical care should be provided that care by the Veterans' Administration. The administration now wants to subject these veterans to a stringent means test regardless of age. This is contrary to current law and opposed in the strongest possible terms by the VFW.

To repeal this law, as this administration intends, and restrict most non-service-connected care to veterans on the rapidly diminishing pension roll and those veterans who are medically indigent does not auger well either for veterans or the future of the Veterans' Administration hospital and medical care system. The retrenchment of Medicare benefits and proportionate increases in necessary Medicare supplemental insurance would work a severe financial hardship on many veterans and subject others to the vagaries of the floundering Medicaid system.

According to the House Select Committee on Aging:

> The impact of a mean test on veterans would be considerable. The added cost to Medicare would be as high as $600 million annually.

Such a mandated continuing reduction in patient load would necessitate reductions in health care personnel, hospital and nursing home care beds, and, in the not too far distant future, a reduction in facilities and ability of the VA to be the primary viable backup to the Department of Defense. The framework would then be in place to disenfranchise all the non-service-connected veterans and contract out care for veterans with service-connected disabilities.

Mr. Chairman, the administration has proposed consolidating into three benefit processing and support activities the adjudication of veterans claims and the maintenance of claims files. The remainder of the 59 VA regional offices would become mere contact points where the veteran could do little more than file a claim, since the claims folders would not be available, and there would be no adjudication at these contact points.

This was proposed originally in the President's fiscal year 1982 budget. The VFW opposed it then. We oppose it now.

The claimant's access to full and fair hearing would be restricted since many who would be able to appear before a board in his own State might well be unable to travel half the distance of the country to make a personal appearance.

Mr. Chairman, the Veterans' Administration Loan Guarantee Program is the most used veterans benefit under which nearly 12 million veterans have purchased homes. Now the administration proposes legislation to increase the user's fee from 1 percent to 5 percent. The 5 percent user's fee, in our opinion, could effectively negate the value of a VA home loan for veterans, particularly Vietnam veterans.

Mr. Chairman, the average, full-time equivalent employment within the Veterans' Administration Department of Medicine and Surgery, as reflected is 192,048 personnel, an increase of 199 over 1985. However, this increase does not in any way enhance care within the existing system since 2,068 FTEE's are allocated to staff new facilities yet to be activated. In reality, the administration Productivity Improvement Program will cut 1,916 personnel and an additional 889 personnel will be lost to existing medical, surgical, and psychiatric bed sections. Obviously, more emphasis is being placed on extended care facilities. However, the VA is still not operating the 90,000 hospital and nursing home care beds mandated by 38 U.S.C. 5010.

Third-party reimbursement, last proposed by President Carter's fiscal year 1981 budget, to save $315 million a year, has again surfaced in this budget but with more modest anticipated savings of $65 million a year. Without delving in depth into the impediments of this proposal, the VA would need, based on its own estimate, as many as 2,495 additional FTEE's to handle this extra administrative burden, which obviously the administration has no intention of providing, in addition to the expanded ADP capability which would be required.

This situation is further compounded by the additional personnel required to implement the proposed medical care means test in this corresponding workload.

Mr. Chairman, the reduction in proposed medical care and research grants for the construction of state extended-care facilities and major construction flies in the face of the VA report entitled "Caring for the Older Veteran." This challenge is not going to go away. We taxpayers are going to pay for the care of our older veterans. It is merely a question of whether it is to be accomplished with dignity for the veteran and in a cost-effective manner within the VA system or bereft of all dignity through reliance on the almost bankrupt and tenuous Medicaid system.

Mr. Chairman, none of us know at this juncture what budget cuts Congress will agree to in the final analysis. However, we of the VFW believe the Veterans' Administration and veterans have made substantial contributions to deficit reduction and that the status quo should now be maintained. If the Members of Congress believe otherwise, let them speak and be counted. After all, the President proposes, but Congress disposes.

And we will be happy to respond to any questions you may have.

[The statement of Mr. Schwab appears at p. 227.]

The CHAIRMAN. Thank you very much. I only have one question. You mentioned about $600 million, I think, you said the Aging Select Committee recommended you put veterans over in Medicare. You want to expound further on that statement?

Mr. SCHWAB. Yes, sir. It is contained in the Select Committee on Aging's report entitled "Aging Brief, the President's 1986 Budget and Assault on America's Aging and Poor," for release February 7, 1985.

The CHAIRMAN. Thank you very much.

Anyone else?

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Donald, would the VFW oppose a simple nonexpensive means test if one can be devised?

Mr. SCHWAB. Would you repeat that, please, sir?

Mr. HAMMERSCHMIDT. Would the VFW oppose a simple nonexpensive means test if one could be devised?

Mr. SCHWAB. Under our current mandates we would, yes.

Mr. HAMMERSCHMIDT. From your field reports after visiting VA hospitals, do you feel that very many affluent veterans have received non-service-connected care?

Mr. SCHWAB. Sir, with your permission I would ask our director of national veterans service, Mr. Juarbe, to respond to that question.

Mr. HAMMERSCHMIDT. We would appreciate it, Mr. Juarbe.

Mr. JUARBE. Sir, I think the experience we have had is definitely that is not the case. I think it has been borne out by the testimony that has been given before us, also. In addition to that, the VA's own estimates show that the majority of veterans who are in the hospitals that are non-service-connected are veterans that are medically indigent, have multiple disabilities, and have little or no health insurance at all, and that is approximately 1½ million of the approximately 3 million veterans that the VA cares for during a year. So our answer to that question is definitely not, sir.

Mr. HAMMERSCHMIDT. Thank you, sir.

Donald or Cooper, what would be the VFW's position if Congress attempted to put a freeze on all COLA's including Social Security?

Mr. HOLT. Basically, Mr. Hammerschmidt, we would probably go along with it if you placed it on everything, as we did the COLA restriction, I think, in the last session of Congress. But you better be sure you do it to everybody.

Mr. HAMMERSCHMIDT. Thank you very much. Thank you for your testimony.

Mr. HOLT. Mr. Chairman, if I may, we are reading an awful lot about slicing veterans programs and we have heard conversation here this morning that history repeats itself. Last night I was going through some papers when I was national commander, in 1956-57. I found this paper and thought it might be interesting to you and your staff, and it is entitled "Eisenhower Maps Cut in Veterans Benefit."

Let me just read one paragraph. It says:

> While the Eisenhower administration is making ready to spend more money to prevent future wars, it is embarking on a method to reduce the cost of past conflict. The President and his aides are preparing for the herculean task of trying to cut back that political untouchable—

Today it is the sacred cow; then it was the untouchable:

> Known as veterans benefits. They are fully aware the attempt may run into stoney opposition.

Sir, that was printed November 25, 1957.

Another article at the same time says:

> The Nation's budget chief has pointed the economy axe at farm subsidies, veterans benefits and housing to obtain more money for defense.

That, too, sir, was published November 21, 1957.

So what we are saying here today is exactly right. I have never known a year since I have been up here that veterans programs were not under attack by somebody. At that particular time it was the Bradley Commission report that they talked about, and I understand yesterday Bobby Muller, president of VVA, went to the Senate and suggested forming another Bradley Commission. Hell, all he needs to do is read that one and he will find out what is going on today. We don't need another Bradley Commission. But today, instead of the Bradley Commission, we have the Grace Commission, and we have had the Heritage Foundation, and we had the CBO—we have everybody attacking veterans programs. As Don says, as long as we can keep our friends in the Congress, we in the VFW are not too concerned about the influence of these people on the Congress.

The CHAIRMAN. Thank you very much, Cooper, for that statement, and you do have a lot of friends in Congress. And I would like to commend the VFW on their strong stand on defense matters, also. If we don't have a strong defense, we are not going to have any veterans programs anyway. It is a matter of balance, and I think we can do it.

I think we have to consider across-the-board freeze. We can provide an adequate defense to deter the Soviets, yet we can protect our veterans programs and hopefully keep the economy moving. That is what we have to try to do, and it can be done. In my opinion, we are living in one of the great eras of life, and we just don't appreciate it. We have some problems. If we talk it through and work hard, we will survive and protect these veterans programs.

Thank you. Thank you very much.

Mr. SCHWAB. Thank you, Mr. Chairman.

The CHAIRMAN. I would like to call the American Legion—Paul Egan, deputy director, national legislative commission; John Sommer, deputy director—to come forward and make their testimony.

STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION

Mr. EGAN. Thank you, Mr. Chairman. We have divided our summary between us and John will begin, but before starting I just would like to draw to Mr. Ridge's attention a study that we completed recently on health care spending trends. And I think that if your staff hasn't received it——

The CHAIRMAN. Just talk into the mike.

Mr. EGAN. If your staff hasn't received it, give us a call and we will get it to you.

Mr. SOMMER. Mr. Chairman, members of the committee, the American Legion certainly appreciates this opportunity to summarize its views on the proposed VA budget for fiscal year 1986. Our comments and concerns are elaborated in our full statement.

We must say that the American Legion does not feel the proposed funding levels are satisfactory to carry out all the programs administered by VA. The portion of the total Federal budget consumed by veterans programs has been steadily shrinking over the past 10 years from a full 5 percent in fiscal year 1975 to 2.7 percent in the current fiscal year. Thus, it cannot be said that veterans are receiving more than their fair share of total Federal dollars, when in fact the contrary is true.

In addressing the legislative initiatives contained in the budget message, we are pleased to see a proposed 4.1 percent COLA in compensation effective December 1. However, the American Legion is opposed to those proposals relating to the home loan program and the repeal of authority for VA education loans. We are also opposed to third-party reimbursement and the implementation of a means test for non-service-connected veterans seeking VA medical care.

We do not feel that these proposals would cost effectively accomplish the purpose for which they are being proposed. The section of the budget message relating to the Department of Veterans Benefits provides funding to accomplish a plan proposed by OMB and that VA is beginning action on which would consolidate DVB benefit and support activities into three regional centers. The proposed concept would eliminate direct service to veterans by denying them the opportunity to present claims in person with the assistance of a veterans service organization.

The individual veteran needs and deserves this opportunity, and the American Legion is totally opposed to the planned consolidation and reorganization as we consider it neither reasonable nor practical.

Chairman Montgomery and Mr. Hammerschmidt, the American Legion deeply appreciates your prompt reaction to the Administrator's correspondence dated February 1 wherein the proposed plan for the reorganization of DVB was only superficially addressed and little justification for that move was given. We are well aware that section 210(b)(2) of the title was enacted following the "midnight massacre" of March 1981 when OMB announced that DVB was to lose over 1,600 employees and the proposal surfaced to consolidate the majority of the operations of the regional offices into one or a maximum of three centralized locations. Fortunately, that proposal was short-lived and we sincerely hope that the proposal now under consideration will meet that same fate.

Again, we appreciate your prompt and genuine expression of interest and concern with respect to the critical issue that is of great concern to America's veterans.

In funding for the Department of Medicine and Surgery, we have several concerns. The proposed medical workloads for fiscal year 1986 show no change in inpatients treated in VA hospitals, which is projected at 1.4 million for the year. The maintenance of average operating beds in the VA system reflects a loss of 1,000 acute care beds, which is deeply disturbing to us.

Another extreme concern is the absence of specific reference in the budget to important medical programs such as inpatient PTSD units, hospital-based home care, adult day care centers and geriatric evaluation units. Other areas of concern are the proposed decrease in medical and prosthetic research, no funds for expansion of the GRECC program, a reduction of funds for State home grants, and a decrease in funding for medical construction.

Mr. Chairman, in our full statement we have addressed a variety of subjects we consider to be of special importance to the Nation's veterans that are included in the budget message for the VA. We have spoken to those programs we believe to be of highest priority in an agency whose activities are all of a high priority because they are intended to respond to the needs, first, of those who were disabled in war service, and then to the reasonable needs of all those who served honorably when called to do so by the Nation.

We endeavor to leave the committee with the understanding that the American Legion does not feel that the administration's request for funding of all programs administered by VA is satisfactory. We have offered specific comment on those areas in which we feel funding is inadequate, and we have addressed each of the legislative initiatives with respect to the concerns of this organization. We trust that the committee will examine and consider the problem areas that we have identified.

Mr. Chairman, Paul Egan will now complete the summary of the American Legion's testimony.

The CHAIRMAN. I want to thank the American Legion for that summary.

Mr. EGAN. As John indicated, we also have some concerns regarding programs for veterans operated by agencies other than the VA. Within the Department of Labor, for example, the American Legion is generally pleased at the proposed 1986 budget for the operation of Department of Labor programs. It contains no significant cuts. However, it must be understood that any cuts in these programs will be felt very deeply because these programs are already operating on a bare bones budget.

I think it is important to note, also, that in the area of employment and training we are looking at the prospective loss of the Targeted Jobs Tax Credit Program at the end of this fiscal year, which we will, for one, be looking to reauthorize, also as we are looking into the winding down of the Emergency Veterans Job Training Program. In that regard, we understand that legislation is going to be introduced by Mr. Solomon and Mr. Leath to extend that program, and we expect to support it.

Back to labor for a moment. For example, an 8-percent cut in travel funding for the Veterans' Employment Service is contemplated in the 1986 budget, and we expect it to significantly hamper the efforts of State directors of veterans' employment in the execution of their outreach responsibilities.

Another example is to cut the funding for the veterans' portion of the Job Training Partnership Act from $9.7 million in 1985 to $7.7 million as proposed for fiscal year 1986. In this case already limited funding for those participating grantees in States is having an effect on the number and the quality of services provided.

In another area the fiscal year 1986 budget contemplates unhitching State employment security agencies, otherwise known as the Job Service, from the Federal Government altogether by fiscal year 1988. Apart from the rationale used to support this proposal, the most obvious and immediate question that remains unanswered is what will become of employment services to veterans operating out of Job Service offices if the proposal is implemented.

In another agency, the Small Business Administration, it is proposed to be completely dissolved. It is, however, only recently that the SBA has been providing veterans with the special consideration in their applications for loan guarantees as provided by law for many years. On balance, the gains made by veterans recently are too significant to be allowed to be reversed.

Mr. Chairman, we recognize that the Housing Memorial Affairs Committee will be holding a hearing on March 5 to hear testimony on the changes proposed for the home loan program. At that time we intend to discuss our vigorous opposition in considerable detail. For now it is significant to state our objection to the proposed increase in the user fee as well as termination of the Administrator's authority to set maximum interest rates. We also note that a further oversight hearing on the home loan program is scheduled for April 18. Given the fact that this committee will mark up its report to the Budget Committee before the April 18 hearing, we strongly urge that you delete any home loan reforms from that report.

As stated earlier in this statement, VA has consumed a shrinking share of total Federal spending and the reasons for this are probably several, but there is one very important reason that must be understood clearly. Unlike most entitlement programs the VA program generally, and readjustment programs specifically, are not open ended. Instead they have built-in efficiencies which guarantee precipitous declines in costs.

The GI bill education program is a classic example. In fiscal year 1975 the cost of VA education was $4.6 billion. In fiscal year 1984 the cost of VA education was only $1.4 billion. In our judgment this is but one example of why it is unwise to hold out the VA budget for cuts on the dubious assumption that fairness somehow dictates that VA must contribute even more than it already has to overall Federal cost containment.

In medical care VA spending between fiscal year 1975 and 1984 rose from $3.7 billion to $8.8 billion; this constitutes an increase of 138 percent. The cost of Medicare spending during the same period rose from $12.9 billion to $62 billion, an increase of 380 percent. In the private sector, medical spending between fiscal year 1975 and 1984 rose from $66.6 billion to $215 billion, or 323 percent. With this in mind, the cumulative increase in the Consumer Price Index from 1975 through 1984 has been 111 percent. Overall, VA spending over the same period has risen only 55 percent, less than half the cumulative CPI. Even in VA expenditures for compensation and pension, the increase is well below the cumulative CPI.

Given the clear restraint in VA spending over the last 10 years by contrast with the cost of spending on other programs, the VA budget has been a model of fiscal prudence, one not needing further restraint beyond that which has already been built in.

Thank you.

[The statement of Messrs. Egan and Sommer appear at p. 239.]

The CHAIRMAN. Thank you. We certainly recognize the American Legion has the largest membership of any of the veterans' organizations in the country.

I have no questions. Does any Member have questions?

Mr. HAMMERSCHMIDT. Mr. Chairman, I have a couple of questions.

What would the position of the American Legion be if Congress attempted to put a freeze on all COLA's, including Social Security?

Mr. SOMMER. Mr. Hammerschmidt, the American Legion would consider acceding to a freeze in COLA's for veterans benefits if all other Federal benefits across the board were frozen.

Mr. HAMMERSCHMIDT. Do you see an increase in funds for the State grants programs as a possible less expensive way of increasing nursing home beds for veterans, and as an alternative to at least part of the VA nursing home construction program?

Mr. SOMMER. An increase in the funding for State home programs would certainly be effective in assisting the veterans in taking care of the aging veteran population within their States. As we have stated in our full statement, there is now a backlog of some 66 requests for grants of funding. If an application were submitted today, it would not receive consideration for funding for some 5 or 6 years. Therefore, there is a definite need for more funding in this program.

As an alternative to construction of VA facilies, that is something we would have to study very closely. This is because the American Legion support for the VA construction program is based on the deteriorating capital plant of the VA and the great need for replacement and modernization projects within the system. So it would be difficult at this juncture to say that it would serve as an alternative to additional construction within the VA system.

Mr. EGAN. Certainly, Mr. Hammerschmidt, to opt for one instead of the other would have to be considered with what we are expecting in terms of health care needs in the future as demonstrated by the VA's report on the aging veteran. Clearly there is going to be an increased need for health care, and clearly there is going to be an additional need for greater availability of that care. Whether or not that need for care can be met with one or the other but not both is an open question.

Mr. HAMMERSCHMIDT. If the proposed 5-percent fee were imposed on GI home loans, what is your best estimate of the effect it would have on the number of such loans being made in fiscal year 1986?

Mr. EGAN. Well, we have no reason to disagree with what the Director of the Home Loan Program has already said in his written statement, which is that it would probably reduce the number of new mortgages by 50 percent.

Mr. HAMMERSCHMIDT. The Legion will recall a means test of the 1950's. And as you probably heard me say in earlier testimony, a financial paper had to be executed by each veteran applying for non-service-connected medical care. Would you care to comment now, or would you like to furnish it for the record, and going back over your own memory and your own records, the Legion experience for that program, and comment on its success or lack of success?

Mr. SOMMER. With your permission, Mr. Hammerschmidt, we would like to address the means test of the 1950's in writing because neither one of us was here at that time.

Mr. HAMMERSCHMIDT. Recognizing that fact, I thought you might want to go to your records and then furnish that to us for the record.[1]

Mr. SOMMER. We appreciate that.

Mr. EGAN. There are probably a couple of things that could be surmised even without having been around in those days, and that is that in order to check on someone's availability to pay, just how intrusive is the VA or some other authority going to be in looking into the background and the financial ability of someone to pay.

With regard to a means test generally, there has got to be a significant difference between any means test imposed on those over 65 and those younger, because there are people who might fall below the means test who are over 65 because they might have a life insurance policy or equity in property, which would disqualify them from VA care. In which case were they to then cash in their life insurance policy and sell whatever equity they have in their property, they could reappear before the VA looking for care and find that because of space availability limitations they are still not eligible.

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[1] See p. 269.

Mr. HAMMERSCHMIDT. I appreciate your contemporary views and how you believe it would affect the veterans at this particular time, but also if we could draw on that bit of history it might be helpful for our records.

Mr. SOMMER. Certainly.

The CHAIRMAN. If there are no further questions, we thank the representatives of the American Legion. Thank you very much.

For the Paralyzed Veterans of America, a good friend of ours, Bob Moran, associate legislative director.

STATEMENT OF BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. MORAN. Thank you, Mr. Chairman. I appreciate the opportunity to appear here today, and I will summarize.

PVA recognizes the need to reduce the Federal deficit, but in examining the proposed fiscal year 1986 VA budget we find targeting of veterans health care and services to be a reprehensible approach and a disservice to the men and women who have served the Nation.

The cost of providing for a Nation's veteran is an obligation that is associated with the continuing cost of our national defense. This year's budget proposal does not even stay abreast of inflation, but more detrimentally, it proposes a reduction in excess of $100 million. This coupled with the ever-increasing demand being placed on the VA system by the aging veteran population, can only result in a reduction and decline in the quality and quantity of service to veterans.

Of critical concern to PVA are the staffing levels proposed for the Department of Medicine and Surgery. By disregarding intended staffing levels for fiscal year 1985 and failing to provide the VA with the 2,000-plus FTEE's needed to staff newly constructed facilities, the proposed budget results in the Department of Medicine and Surgery being 4,000-plus employees below the number needed.

The VA's fiscal year 1986 proposed construction budget of $611 million in new budget authority indicates the administration is not recognizing the importance of maintaining and building adequate facilities if the VA is to perform its assigned functions. This is particularly true regarding the emphasis on the construction of new nursing homes. Indication of intended future policy is to be found in the administration's limitation of nursing home construction to two 120-bed facilities in fiscal year 1986, and a reduction of 720 beds from the level requested.

Concerning the means test, PVA does not oppose, per se, a means test. Institution of any means test, however, must be equitable, being applied to all non-service-connected veterans, regardless of age, and it must address factors other than gross household income. Significant factors such as totality of a veteran's health care needs must be considered in making eligibility determinations rather than relying on a single episode determination. The criteria for determining what is household income poses a significant problem.

Finally, the question of cost effectiveness must be raised. The institution nationwide of a proposed means test implies significant administrative costs with no assurances that the VA will realize savings. If the means test were to phase out certain veterans with the ability to pay, others currently being denied care would only be admitted to the system.

PVA also must address the implications of this budget for the Department of Veterans Benefits. The essence of the plan is the consolidation of various regional offices and centers into three regional centers located in Eastern, Central, and Western United States. An appropriation of $25 million is to be allocated for cost of consolidation. We challenge the estimate as grossly inadequate. Our challenge is also based on consideration of the cost of finding and leasing, buying, or building suitable quarters for the consolidated offices, overlapping leases and costs or breaking of leases, packing, shipping, relocation of files, installation costs of telephonic and other communications equipment, direct and indirect employee costs such as severance pay, early retirement and the inevitable loss of production and deterioration of employee morale as office closings and relocations become imminent.

Also, taking into consideration the relocation as well as the loss in work force, we feel it is imperative that the VA consider the loss of free assistance afforded them by veterans service organizations. For example, the combined veterans organizations last year alone handled approximately 35 percent of all claims filed in 40,000 personal hearings, both formal and informal.

In summary, indications are that the proposed DVB cut was made arbitrarily and the proposed consolidation of regional offices into three locations was made in desperation on orders to cut costs rather than by plan. Another issue of concern to the members of PVA is a proposal regarding the VA's home loan guaranty program. PVA believes the proposal of a 5 percent user fee in the fiscal year 1986 budget is the start to the liquidation of this hugely successful program.

In closing, Mr. Chairman, it is PVA's belief that there are areas within the Veterans' Administration which, if properly addressed, can be made more cost effective and efficient. It is recommended that this committee, and Congress as a whole, require the agency to submit a comprehensive, automated data processing initiative to the Congress prior to the submission of the fiscal year 1987 budget.

This concludes my statement, and I will be glad to respond to any questions.

[The statement of Mr. Moran appears at p. 275.]

The CHAIRMAN. Thank you very much, Bob. We always enjoy having the PVA here and having you before our committee.

Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you very much, Bob, for your fine testimony. Let me ask you the same questions I have asked the other service organizations.

What would the PVA's position be if Congress attempted to put a freeze on all COLA's, including Social Security?

Mr. MORAN. Again, if it was across-the-board, PVA could support that.

Mr. HAMMERSCHMIDT. We are very appreciative for your response and for your fine testimony. You always give us very comprehensive testimony. And let me say that I know our committee members want to send Dr. Custis our very best wishes. Is he still in the hospital?

Mr. MORAN. Yes; I understand he is. I haven't been in the office for a day or two, but I understand he is. We appreciate it and we will relay that message.

Mr. HAMMERSCHMIDT. Please send him our very best regards.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Bob.

We only have two witnesses left. The Non-Commissioned Officers Association, Richard Johnson, director of legislative affairs. I would also like to thank Richard for his help especially coming from the Non-Commissioned Officers on the GI bill and the interest that you have shown in other areas affecting noncommissioned officers over the years.

STATEMENT OF RICHARD W. JOHNSON, JR., DIRECTOR OF LEGISLATIVE AFFAIRS, THE NON-COMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA

Mr. JOHNSON. Thank you, Mr. Chairman, that is most kind of you. And we certainly appreciate the fact that we would not have a new GI bill today had it not been for the concern and the leadership that you have given the issue.

The CHAIRMAN. Actually it all started in this committee with Mr. Hammerschmidt and others. The committee didn't get much publicity because it got headaches in the Armed Services Committee over in the Senate. But this committee was the one that started it, and they were unanimous. And now we have to make it work, make the Defense Department implement it.

Mr. JOHNSON. We are making points over there, I believe, Mr. Chairman. I think they are beginning to see the value of it, particularly in the Air Force now.

The CHAIRMAN. It is getting off the subject, but it certainly is important to this committee that we have a strong defense. The recruitment is falling off, as you know, because of shortage of young manpower and because jobs are more plentiful. They have an opportunity here to implement this legislation that you and others had something to do with.

Mr. JOHNSON. Well, we look forward to working with you, Mr. Chairman, on that, and also working with Defense to try and convince them it is in their best interest to fully implement that program.

Realizing that the committee is under some time constraints this morning, I will not read my prepared statement. In point of fact, I may not even read my prepared summary.

The CHAIRMAN. Well, why don't you go for 5 minutes. That is a vote.

Mr. JOHNSON. Let me attempt to be very brief, Mr. Chairman. Since 1975, as you well know, expenditures as a percentage of Federal outlays on behalf of veterans have declined substantially. Nevertheless some of this decline was a result of reduced services requested by veterans. At the same time, in those same budgets, each of them provided limited growth in veterans programs. And at the same time structural changes in veterans programs and benefits have led to a savings of well over a billion dollars contributed by veterans in this country.

The budget proposal now under consideration by the committee provides no real growth. Indeed, it is difficult to find in that budget a major category of expenditures that hasn't been targeted for program cuts or program changes in some way.

NCOA strongly supports a 4.1 percent increase in compensation and survivor benefits that has been proposed by the administration. At the same time we are deeply opposed to regional office function and consolidation, which by the VA's own admission is ill-considered. Again by the VA's own admission changes proposed in the home loan guarantee program may irreparably damage it and they, too, do not have a foundation for the projections they have made on the savings.

With regard to implementation of a means test, we believe that this suggestion is based on the faulty premise that assumes that there are veterans receiving treatment in VA facilities that can otherwise afford to provide their own care. We just don't think that the VA, and again by their own admission, they do not have any idea what the impact of this initiative will be on the veteran.

And while these hearings are focused on those issues, there are other issues of concern in that Veterans' Administration budget, which for lack of a better term are the more mundane issues of day-to-day operations of the Veterans' Administration. A proposed reduction in medical and prosthetic research; proposed reductions in the bed structure and the realignment of bed structure in the hospital system; proposed reductions in Board of Veterans Appeals outlays and expenses, general operating expenses in an area where there is still a backlog of cases that are substantial.

And altogether, and in final summary, the whole budget proposal seems built on so many ifs, so many maybes, that it, in our opinion, will not stand. Unless this committee uses its full jurisdiction and influence with the Budget Committee to add at least $1 billion to provide really a maintenance increase in the VA budget, we do not think that the programs will survive.

That concludes my summary, Mr. Chairman.

[The statement of Mr. Johnson appears at p. 299.]

The CHAIRMAN. You are recommending $1 billion, you say?

Mr. JOHNSON. Yes, sir.

The CHAIRMAN. Current services?

Mr. JOHNSON. I beg your pardon, sir?

The CHAIRMAN. Current services budget.

Mr. JOHNSON. We are overall recommending that $1 billion be added to the budget which would facilitate keeping the regional office structure as it is, which would facilitate keeping the VA Loan Guarantee Program as it is, and so forth. At the same time, the addition would provide some restorations in medical research, prosthetic research, which at the same time would provide some increase in the ability of the Board of Veterans Appeals to do its job and diminish its backlog, and would provide some real growth in those veterans programs which have been so important through the years.

The CHAIRMAN. Mr. Hammerschmidt?

Mr. HAMMERSCHMIDT. I want to submit a question to you just so you can respond in writing and save time here, since we are under the constraints of a vote here in about one minute.[1]

Mr. JOHNSON. Yes, sir.

Anticipating a question from Mr. Hammerschmidt, may I have the indulgence of the committee to remark on questions that you have asked previous witnesses with regard to supporting the 4.1 percent increase?

Mr. HAMMERSCHMIDT. Yes, we would appreciate your response to that question.

Mr. JOHNSON. I think Colonel Passamaneck hit on a very salient point in responding to that question earlier, and that is that we have a tendency to lump all Federal benefit programs together in a single category and say we will provide cost-of-living increases or we won't as a lump. And we tend to disregard the fact that there are very, very different reasons for those programs to exist. Some of them are indeed welfare programs. Some of them are earned entitlements that should be protected.

For example, in the District of Columbia right now a welfare mother earns as much in AFDC, food stamps and so forth, as a military retiree in Grade E–6, and almost as much as an E–7.

The CHAIRMAN. We are going to have to cut you off to make the vote.

Mr. JOHNSON. I am sorry, Mr. Chairman.

The CHAIRMAN. That is all right, I understand it.

In fairness to VVA, we will just have to come back. And if you want to, Dick, continue your comments.

But the committee stands in recess for 10 minutes.

[Recess.]

The CHAIRMAN. We will continue to hear from Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman. I just wanted to complete one thought for the committee, and that is that we tend to group these COLA increases into categories. And I want to point out the distinction that Colonel Passamaneck made this morning and that is that there is no clear and concise reason that we should do this. These benefits are paid to different people for different purposes. Some are, in fact, welfare benefits. Some are, in fact, earned entitlements, and they should be viewed as such. Now, if the problems in the programs are systemic, we need to correct the programs, but not just to go around and summarily cut COLA benefits and not necessarily cut all COLA benefits just because we feed to produce a cost savings.

The CHAIRMAN. Thank you very much.

Tom Ridge, a Vietnam veteran, do you have any questions?

Mr. RIDGE. No questions, Mr. Chairman.

The CHAIRMAN. Thank you for waiting. And I apologize to the audience here. We might have a few more votes today before it is all over with.

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[1] See p. 306.

John Terzano, vice president of the Vietnam Veterans of America, and Mr. Dennis Rhoades, the executive director, we are glad to hear from you.

STATEMENT OF JOHN TERZANO, VICE PRESIDENT, VIETNAM VETERANS OF AMERICA INC., ACCOMPANIED BY DENNIS RHOADES, EXECUTIVE DIRECTOR

Mr. TERZANO. Thank you, Mr. Chairman.

It is unfortunate that Mr. Holt's schedule wouldn't permit him to stay because I am sure he knows VVA has been the only Veterans organization that actually adopted the Bradley Commission's philosophy governing veterans benefits. And I would suspect that if one read in the complete article that Mr. Holt quoted from this morning that one would probably see the VFW blasting the Bradley Commission and the report. Remember, some of the Veterans organizations helped bury the Bradley Commission Report.

But the point is not whether the Bradley Commission's philosophy is still applicable today. A lot has happened since that report has come out. Two new GI bills, and two pension programs have been instituted, also health care has changed dramatically within the VA. I think the time has come for this Nation and this Congress to take a look and reevaluate not only the programs and services that the VA provides, but also the philosophy that will govern it. Is it fair, for example, that an individual who was wounded on the field of battle, who has a service-connected disability, that this health care and compensation be the same as an individual who never left the States, whose injury occurred in an auto accident on a weekend leave.

This country owes first and foremost an obligation to those wounded on the field of battle. But should we afford the same benefits, the same health care, the same compensation for somebody who didn't? These are types of questions that need to be addressed.

The VA Hospital up in the Bronx New York, has an 80-bed spinal cord unit. Forty of those beds are currently filled with only four of them being service-connected veterans. What can be done with a system that operates like this? The current system needs to reevaluated. If we don't take a step back and look at the system today what is going to happen to the future generations of veterans. Because if the system continues willy-nilly down the road as it is doing, then the veterans that are following us, the last group of men and women that this country sent to war, are going to have a system that will be totally inadequate to address their problems and needs.

I strongly urge this committee to seriously consider working with us and the Senate in establishing a new commission on veterans programs and services.

At this time I would like to ask Dennis Rhoades just to comment on a couple of specifics on the VA budget.

Mr. RHOADES. I think we would be remiss, Mr. Chairman, if we didn't affirm our support for a 2- to 3-year extension of the Emergency Veterans Job Training Act. As you know, VVA has been one of the principal supporters of the program. The program is now rolling, and realizing it is unpopular to ask for additional moneys in this Congress for a program, we feel that rather than a pure outlay and income transfer, the EVJTA is an investment in the long-term economic good health of Vietnam veterans and the Nation. We urge this committee to fully support the extension for the next 2 to 3 years, because we think it is going to require that length of time to really get on top of the structural unemployment problems of Vietnam Veterans.

I must say also that we oppose the consolidation of DVB as it is currently outlined. We are particularly concerned about the rating boards being consolidated in three regional offices. We have been made to understand that the proposal is to have traveling rating boards. But if the traveling rating boards work as well as the BVA's traveling panels I think the whole adjudicatory system in the VA is in big trouble.

That is all our comments for now, Mr. Chairman, in summary. Thank you.

[The statement of Bobby O. Muller, president, Vietnam Veterans of America, Inc., appears on p. 307.]

The CHAIRMAN. Well, thank you.

The Chair recognizes Mr. Ridge, and then the Chair will ask a couple of questions and make some comments.

Mr. Ridge.

Mr. RIDGE. Thank you, Mr. Chairman.

I think you once told me that if I worked hard on the committee, it would recognize my talent and maybe I would progress. I notice I started at the committee meeting over there and I am now seated next to you. I want to tell you we didn't get promoted that quick in the service; so, obviously, you are a man of your word.

Gentlemen, on page 2 your statement, actually the statement you sent for Mr. Muller, you refer to a possible compensation increase. You also have stated that you do not in principal oppose a freeze on income transfer programs. Does this mean that if all COLA's were frozen—you probably will be surprised at this question if you haven't heard it before—including Social Security, that you would not object if a compensation increase did not materialize?

Mr. RHOADES. Yes, sir; that is correct. We feel that if the Congress freezes COLA's they need to be frozen absolutely across the board. As has been pointed out earlier in this hearing, the income transfer programs operated by the Federal Government exist for different reasons. We believe that you really can't make the kinds of distinctions necessary to say, well, one COLA is going to survive and one is not. And that is particularly true with compensation and pension.

If Congress is going to freeze COLA's, freeze them across the board.

Mr. RIDGE. You mentioned as well that an eligibility level of $15,000 is too low for a means test for medical care. Obviously you have given it some thought. Assuming, and I am not saying that there should be, but assuming there was a means test for nonservice connected, what level would you recommend if not $15,000?

Mr. RHOADES. Well, in the first place, what bothers us about the $15,000 proposal is how vaguely sketched it is. It doesn't address the issue of insurance. It doesn't address the issue of assets that may be in the bank, particularly retirement assets. It talks about gross annual income, but we don't really know what that means. If there is going to be a spend-down provision, does a veteran have to spend his or her assets down to $15,000?

Earlier this year, the VA Administrator presented another kind of a means test, which would provide for a sliding scale based on income. We think that this means test has some technical problems and may be difficult to administer because of a lot of the determinations that need to be made like the cost of medical care. Nevertheless, we would prefer the sliding scale rather than an absolute cutoff of $15,000.

Mr. RIDGE. Thank you.

Mr. Chairman, it looks like we have another vote. I had one more question, and with your consent would that be all right? Thank You.

The Bradley Commission's secretariat was headed by an OMB official, and it was claimed by some of its critics that this made it lack objectivity. Now, when you make your recommendations for a review mechanism, and I think many of us appreciate your point of view that a comprehensive review perspective, taking a look at where we will be and what our needs will be in the future, is certainly needed. How would you address that issue? Or better yet, how do you avoid it? What kind of review mechanism do you think would be most impartial and most effective?

Mr. TERZANO. We are currently doing an indepth review of what we believe may be best.

I would say, however, that we as veterans in this country have basically two choices: We could either let OMB and the Grace Commission take the lead; or else we can have the courage to move forward and take the lead.

Mr. RHOADES. Excuse me. We have had a lot of study of the VA recently. We have had the Grace Commission which studied dollars, and the Heritage Foundation which recommended cuts based I think on ideological grounds more than anything else. And it seems to me what we haven't really considered, which we ought to be considering first and foremost, is the need of the veteran in this country today. And we would like to see a well-balanced kind of review mechanism set up to do exactly that.

Mr. RIDGE. Well, we look forward to that testimony next week. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Tom.

You know, and I agree, you need to look to the future on veterans programs: how do you handle compensation and where we are headed with veterans programs. The problem is with these committees. Our experience has been with commissions and committees we have come out pretty poorly as far as veterans programs are concerned. And if they come back in here and recommend we do away with half of these programs, then we are worse off, and we spend all of our time trying to fight the commission, which we did several years ago. Seven or eight years ago it was recommended we consolidate and open up our veteran hospitals by a commission that we paid for and formed.

So, John, I would be a little slow and maybe move around a little more and find out about it before we start recommending more commissions. You have a lot of friends in Congress. And so far we have been able to do the things that needed to be done. We don't do everything, but we are not getting along too badly. And when you start getting a commission, we don't know how it will come out. It depends on who you appoint. We can't control it sometimes.

Mr. TERZANO. Mr. Chairman, President Eisenhower appointed Gen. Omar Bradley to head the commission and nobody could argue with his sympathy, or empathy toward the common soldier, and yet the veterans organizations in this country totally dismissed his recommendations. And remember his recommendations supported the premise that, first and foremost, this country's obligation to the service-connected veteran, to provide him the necessary health care and compensation, and then to provide the readjustment programs necessary to bring those who serve on parity with those who did not serve. And once you do that, then the Government's obligation is over.

Sure it is fraught with peril. But I think that if we could come up with a bipartisan commission made up of Members of Congress, the executive branch and people from veterans organizations, we could define a philosophy that is going to govern veterans benefits. Because right now we don't have a philosophy.

The CHAIRMAN. Well, we get along pretty well. We don't get all we want, but the top priority is the service-connected veteran. And then someone pointed out to me not long ago, and I thought about it, that there are people who are not service-connected who had terrific combat records. So you know when you start putting restrictions on those, some of those really fought very bravely, and if you start putting restrictions on who gets what and what priorities they get, then some of our most decorated people are not service-connected. So that is a problem we have.

And then if you start limiting everything to service-connected veterans, then you are going to lose your hospital system, and you are going to lose some of the other programs. You have to kind of do it across the board, the way I am looking at it.

I will say this for the VVA: You always have ideas, keep it up.

For the record, without objection, we would like to submit questions not only to the witnesses at the table now, but to the other witnesses who have testified here this morning. And we will keep the record open for that. It has been a good hearing. I wish more members had been here, because you learn a lot from witnesses, and it has been very constructive.

Mr. TERZANO. Thank you, Mr. Chairman.

The CHAIRMAN. The committee now stands adjourned.

[Whereupon, at 12 noon, the committee was adjourned, to reconvene subject to the call of the Chair.]

APPENDIX

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February 11, 1985

Honorable Harry N. Walters
Administrator of Veterans Affairs
Veterans Administration
Washington, D. C. 20420

Dear Mr. Administrator:

Thank you for your letter of February 1 notifying us of your intention to proceed with a planned reorganization of the Department of Veterans Benefits proposed by the President in his 1986 budget request.

In accordance with the provisions of section 210(b)(2) of title 38, before the Administrator may implement an administrative reorganization in any fiscal year, the Administrator must, under certain circumstances, first submit to the appropriate committees of the Congress a report containing a detailed plan and justification for the administrative reorganization. Such report shall be submitted not later than the day on which the President, pursuant to section 1105 of title 31, submits to the Congress the budget for the fiscal year in which the administrative reorganization is to be implemented. In addition, no action to carry out the reorganization may be taken after the submission of such report until the first day of such fiscal year.

Mr. Administrator, if the two-page letter of February 1 is supposed to be the detailed plan and justification required under 210(b)(2), it is inadequate. For example, the statute requires that you inform the committee of how the consolidation would enable you to take better advantage of the advances of recent years in management and communications technology, as you suggest it would do. We expect you to set out how the proposed consolidation would further improve the agency's delivery of veterans benefits and provide for continuing high quality service to veterans. We're not aware of any effort being made to purchase high tech equipment that would enable the agency to offset the reduction of employees by 17 percent over the 1986-88 time frame as you indicate in your letter.

The committee would be interested in knowing how the FY 1986 reduction of 624 FTEE would affect each individual station. The committee would like a breakdown by regional office of the total number of FTEE losses over the three-year period. You state that the employee reduction would be accomplished through centralization of the designated functions. The committee expects to have the specifics of how this would be accomplished. We want to know more about the staff reductions projected to take place through attrition. For example, have any surveys been conducted as to how many staff you expect to leave the agency over this three-year period through attrition? Are you aware of any specific data that would indicate the number of voluntary reassignments that would take place? Finally, we would be interested in knowing more details about the specific incentives for employee placement which you envision.

The committee would like to know what sites have been surveyed and/or selected for the three centralized locations where consolidation would take place. You indicate that a task force has been established to develop an implementation plan by July 1985 and that the task force will provide definitive plans on locations and relocation strategies, as well as detailed estimates on translocation and equipment costs. We would suggest to you that under the statute cited above, unless the detailed plan is submitted by the date specified (which has now passed) the agency is without authority to make this move; therefore, the move is not to take place in July of 1986 or at any future time unless there is total compliance with current law.

We would be pleased to discuss this matter with you further should you desire to do so.

Sincerely,

Sonny
G. V. (SONNY) MONTGOMERY
Chairman

John Paul
JOHN PAUL HAMMERSCHMIDT
Ranking Minority Member

GVM/JPH:cls

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January 14, 1985

Honorable David A. Stockman
Director
Office of Management and Budget
Washington, D. C. 20503

Dear Dave:

Having seen you on the David Brinkley show yesterday, I'd like to respond to something you said during the program. You did very well as you always do; however, I must take issue with a statement you made about the health care of certain veterans.

I am very concerned that you would categorize the treatment of non-service-connected veterans in VA hospitals as "a sacred cow". The treatment of non-service-connected veterans in Veterans Administration hospitals is limited by law. These veterans can only be treated if space and resources are available for such treatment at the time their application is submitted. According to VA's estimate, more than 200,000 non-service-connected disabled veterans needing care are being turned away each year.

Our Committee has cooperated with the Administration in trying to make the Veterans Administration more cost effective. Based on the President's budget during the past four years, our Committee and the Congress have taken action that will result in savings in FY 81 - 84 of more than $1 billion. Among many cost-savings provisions, we have taken action to terminate flight training, limit correspondence training, eliminate certain dental benefits, delay cost-of-living increases for veterans drawing compensation and pension, limit burial benefits and revise the VA home loan guaranty program, including a requirement that the veteran pay a one percent loan origination fee for a VA home loan (which I personally thought was a big mistake).

I don't think it is fair to suggest that veterans programs could be referred to as "a sacred cow" in any form. I think a review of what we have accomplished in the last four years will establish that fact.

Dave, many government programs (percentage-wise) in the last five years have shown substantial growth. That is not the case with veterans programs. As Chairman of the Committee on Veterans' Affairs, I will oppose any further reductions in our medical program. That is not to say that I will not provide leadership to make some adjustments where I feel it will not adversely affect the ability of deserving veterans to receive care and treatment when they need it. As the saying goes, "They've earned it."

On the cost-of-living issue, I will oppose any effort to freeze compensation and pension increases unless there is a freeze across-the-board for all other federal recipients. All groups must be treated alike. Veterans cannot be treated any differently than social security recipients. I think you will find that if the freeze is applied fairly and across-the-board, veterans will not object. If any group is to receive a cost-of-living increase, I can assure you veterans will insist that they receive an increase as well.

The federal government has obligations of varying degrees to many citizens of this country; however, I firmly believe that no segment of our society is more deserving of benefits and services from the federal government than veterans who have served their nation in time of need. That obligation must be honored. When Congress establishes its priorities and begins to conduct an analysis of those who can sustain reductions and those who cannot, veterans will be rated among the top of those who will have their obligations fulfilled.

I look forward to working with you and other members of the Administration as we seek to resolve our differences on these issues.

Sincerely,

Sonny Montgomery

G. V. (SONNY) MONTGOMERY
Chairman

GVM:clg

cc: Honorable Ronald W. Reagan
Honorable George Bush
Honorable Thomas P. O'Neill, Jr.
Honorable Robert H. Michel
Honorable Frank H. Murkowski
Honorable Alan Cranston
Honorable William H. Gray III
Honorable Delbert L. Latta

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January 9, 1985

The President
The White House
Washington, D. C. 20500

Dear Mr. President:

I have read with great interest and considerable misgivings Secretary Regan's proposal to tax service-connected veterans' compensation. These benefits have from their inception been exempted from taxation, and I cannot imagine any justification that would warrant a departure from this long-standing policy.

Veterans compensation is designed to replace lost earning capacity attributable to disability. Since the benefit has traditionally been tax exempt, the rates reflect this status. For example, the rate for a single veteran who is totally disabled is only $15,540 per year. The difference between this rate and the average earnings of wage earners today reflects the tax exempt status of compensation benefits. To use the language of Treasury policy analysts, the present benefit rates are calculated on a "net replacement" basis. If the benefit were to be taxed, we in the Congress would have to raise the rates to their average earning loss equivalent. This action would probably more than offset the increased taxes to be realized.

Consider also that in addition to a proposed tax on the benefit, it has been proposed to deny a COLA in FY 1986. Taken together, the effect of these two policies is a double penalty imposed on some of our most deserving citizens, those who suffered grievous loss in the service of our country. It is indeed ironic that some of our most deserving citizens should have to bear an unjustly heavy tax burden.

The Congress has long recognized that changes in the structure of the labor market also change the effects that various disability levels have on earning capacity. We have adjusted to this by making the compensation rates incremental rather than straight line. For example, the rate for a 10% disability ($66 per month) is only 5% of the rate for total disability and the rate for 90% ($779 per month) is only 60% of the total rate. The proposed tax credit of 15% on up to $6,000 of compensation for an individual is much more beneficial to the less disabled veteran than to those with more profound disability. Not only is this grossly unfair, but it also flies in the face of what we have been trying to do with the rate structure.

Armed services retirees who also have service-connected disabilities are precluded by law from drawing retirement and compensation concurrently. Instead, they must waive so much of their retirement pay as equals compensation. They do this only because compensation is not taxable and retirement based on length of service is. These retirees have continued to pressure this Committee for costly legislation that removes the prohibition against dual payments. With your proposal vitiating the benefit they receive by waiving retirement pay to receive compensation, the pressure on this Committee to permit receipt of both compensation and retired pay would be greatly increased.

I have tentatively scheduled a full Committee hearing on February 20, 1985 to hear from the Administrator of Veterans' Affairs on the VA budget. In view of the adverse impact the taxing of compensation would have on service-connected disabled veterans, we must hear Secretary Regan's justification for his recommendation to you, and I will insist that he or his spokesman appear before the Committee on that date to present the Administration's views and to answer questions relating to the proposal.

In order to prepare for that hearing, please have Secretary Regan provide answers to the following questions:

1. Would all Federal payments based on disability be taxed; e.g. disability benefits from social security, military retirement, Federal employees compensation, damage awards that are paid as compensation for civilian injury or death, etc.? If there are any exclusions, what is the rationale for the exclusion?

2. What is the estimated revenue to be realized from taxing compensation?

3. Please provide me with examples of how Secretary Regan's proposal and his tax credit would apply to veterans receiving each of the rates for the disabilities specified in title 38, U.S.C. 314 (a) through (s)?

4. VA compensation is based on "average impairments of earning capacity resulting from such injuries in civil occupations" so there is no penalty for overcoming the handicap of a disability. Thus, many totally disabled veterans have overcome their handicaps, returned to productive employment and pay taxes on their earnings. Have any efforts been made to calculate the tax loss attributable to the disincentive effect of your proposal on such veterans?

5. In addition to the basic percentage of disability rates, the law also provides special rates for veterans with special needs. For example, title 38, U.S.C. 314 (l) and (r) pay special rates based on disabilities so profound they require the aid and attendance of another person. Does Secretary Regan's proposal contemplate a deduction for the amounts actually expended for this purpose?

Mr. President, I trust you will not favorably consider this recommendation when you submit your budget to the Congress early next month.

Sincerely,

Sonny Montgomery

G. V. (SONNY) MONTGOMERY
Chairman

GVM:jr

cc: Secretary Donald Regan
Honorable Harry N. Walters
Honorable Frank H. Murkowski
Honorable Alan Cranston

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NANCY LEE JOHNSON, CONN.

February 7, 1985

Honorable James A. Baker III
Secretary of the Treasury
15th and Pennsylvania Avenue
Washington, D. C. 20220

Dear Mr. Secretary:

Enclosed are copies of letters recently sent to the President expressing our views on a provision of the tax reform measure proposed by former Secretary Regan concerning taxation of compensation paid to service-connected veterans. Following your confirmation by the Senate, we were informed by your staff that you would be reviewing the tax reform proposal. It has been suggested that pending such review and your recommendations to the President, it would be premature to hear from the Treasury Department during our hearings on February 20 and 21. We agree.

We understand your desire to review in detail the tax reform package submitted by the former Secretary and, in that regard, will not insist that Treasury officials testify at our hearings; however, all of our members are anxious to know your views in reference to whether the compensation received by service-connected disabled veterans should be subject to Federal taxation. You can appreciate the many calls being received by members of both the House and Senate on this issue since it has been highly publicized by all the national veterans service organizations.

It would be most helpful to those of us who serve on the Veterans' Affairs Committee to know your views on this aspect of the tax reform package. During his State of the Union address Wednesday evening, the President said: "One thing that tax reform will not be is a tax increase in disguise. We will not jeopardize the mortgage-interest deduction that families need." Mr. Secretary, the taxing of compensation is a tax increase for the most deserving of our citizens and surely you and the President would not want to jeopardize the income provided them for their loss of earning capacity due to disabilities incurred in military service.

We are advised by the Ways and Means Committee that the Chairman has scheduled a hearing on February 27 to hear from you in reference to tax reform. We would like to have your views on the veterans tax issue by such date.

Sincerely,

Sonny Montgomery
G. V. (SONNY) MONTGOMERY
Chairman

John Paul
JOHN PAUL HAMMERSCHMIDT
Ranking Minority Member

GVM:clg

/Bob Edgar, M.C.

STATEMENT OF HON. BOB EDGAR, CHAIRMAN
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
ON THE FULL COMMITTEE BUDGET HEARING
FEBRUARY 20, 1985

THANK YOU, MR. CHAIRMAN.

I WANT TO PREFACE MY REMARKS TODAY WITH SOME THOUGHTS ABOUT THIS COMMITTEE AND ITS CHAIRMAN. I BELIEVE THAT THE CHAIRMAN IS IN THE ENVIABLE POSITION OF BEING THE MOST RESPECTED AND WIDELY QUOTED AUTHORITY ON VETERANS MATTERS IN THE NATION TODAY. I SAY THAT WITH DUE RESPECT FOR OUR PRINCIPAL WITNESS TODAY, MR. WALTERS. IT IS JUST THAT SONNY MONTGOMERY HAS WORKED HARDER THAN ANY MEMBER OF CONGRESS TO ASSURE, WITH REGARD TO VETERANS' MATTERS, THAT THIS NATION IS MOVING FORWARD. I AM ALSO PERSONALLY GRATEFUL FOR THE COURTESY THAT THE CHAIRMAN HAS EXTENDED TO ME SO THAT WE COULD GET OUR SUBCOMMITTEE HEARING SCHEDULE UNDERWAY ON THE SAME DAY THAT THE FULL COMMITTEE WAS ORGANIZED. ALTHOUGH I HEARD THE CHAIRMAN SAY HE "SLIPPED UP", I JUST WANT TO EXPRESS MY APPRECIATION FOR HIS "SLIP", AS WELL AS FOR MR. HAMMERSCHMIDT'S COOPERATION.

THERE ARE MANY ISSUES THAT WE BEGAN TO EXPLORE WITH DR. DITZLER TWO WEEKS AGO THAT WE HOPE WILL BE MORE COMPLETELY ADDRESSED TODAY BY THE ADMINISTRATOR.

I BELIEVE THAT THIS CHART, WHICH DEPICTS THE ACTUAL AND CONSTANT DOLLAR VALUE OF THE FUNDS MADE AVAILABLE FOR MEDICAL CARE OF VETERANS, SHOULD BE MADE A PART OF TODAY'S HEARING RECORD. THE CHART IS MOST USEFUL IN ORDER TO GAIN A PERSPECTIVE

OF THE ACTUAL STATE OF THE MEDICAL CARE BUDGET. AS ANYONE CAN SEE, THERE HAS NOT BEEN A "REAL" INCREASE IN THE RESOURCES FOR MEDICAL CARE.

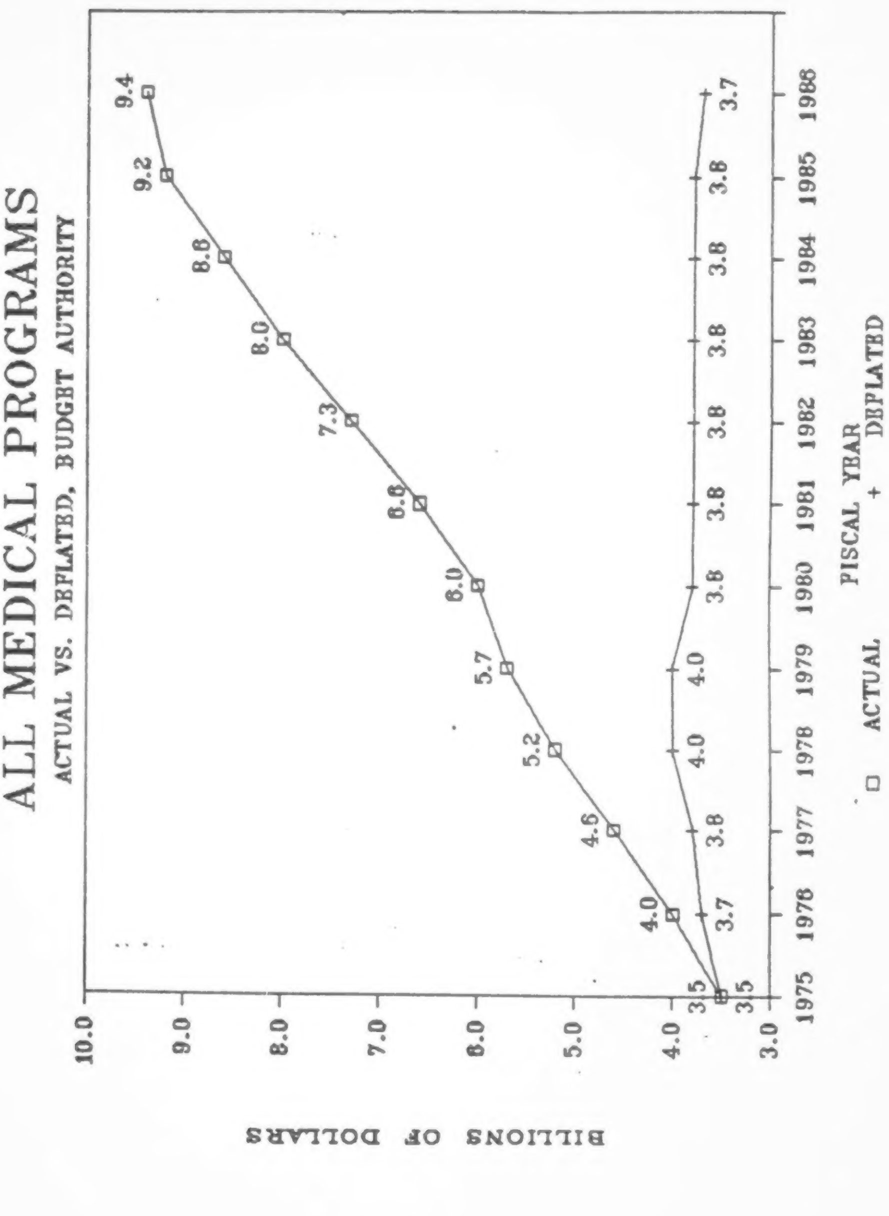
THREE ISSUES ARE AT THE TOP OF THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE'S LIST OF MAJOR CONCERNS. THE FIRST IS THE DISGUISED REDUCTION IN NECESSARY STAFFING FOR THE VA'S HEALTH CARE SYSTEM. I SAY DISGUISED BECAUSE THE FY '85 BUDGET FIGURES HAVE BEEN ADJUSTED TO REFLECT THE 1986 "MARK" WHICH THE VA RECEIVED FROM OMB. IN ADDITION, A CUT OF 1% IN THE NUMBER OF EMPLOYEES IS PRESUMED TO ALMOST COMPLETELY OFFSET THE NEED FOR 2,068 STAFF FOR MEDICAL FACILITY ACTIVATIONS. WE HAVE RECENTLY LEARNED THAT INPATIENT AND OUTPATIENT WORKLOADS FOR THIS YEAR ARE SIGNIFICANTLY HIGHER THAN ORIGINALLY ESTIMATED. THIS MEANS THAT THE CUTS IN THE 1985 BUDGET AND EMPLOYMENT LEVELS DO NOT REFLECT ACTUAL EXPERIENCE, BUT WISHFUL THINKING ON THE PART OF OMB.

THE SECOND ISSUE CONCERNS THE LEGISLATIVE INITIATIVES CONTAINED IN THE PRESIDENT'S BUDGET MESSAGE. OUR SUBCOMMITTEE HAS NOT SCHEDULED HEARINGS ON THESE INITIATIVES BECAUSE THE ADMINISTRATION HAS NOT FORMALLY TRANSMITTED ITS PROPOSAL TO THE CONGRESS. THESE ARE VERY SIGNIFICANT CHANGES WHICH THE ADMINISTRATION IS RECOMMENDING. I DO NOT BELIEVE THAT WE CAN FULFILL OUR ROLE AS LEGISLATORS AND GIVE CAREFUL CONSIDERATION TO

THESE PROPOSALS IF THE ADMINISTRATION DOES NOT SUBMIT THEM UNTIL APRIL OR MAY. IN FACT, OUR RECOMMENDATION TO THE BUDGET COMMITTEE IS DUE ON MARCH 15TH. HOW CAN WE RECOMMEND AN INITIATIVE THAT WE HAVE NOT YET OFFICIALLY RECEIVED?

THE THIRD ISSUE IS PRESENTED BY THE INFORMATION CONTAINED IN THE VA'S REPORT ON "CARING FOR THE OLDER VETERAN." IF THE LEGISLATIVE INITIATIVES TO CURTAIL ELIGIBILITY AND REQUIRE THIRD PARTY REIMBURSEMENT ARE THE ADMINISTRATION'S RESPONSE TO THE INFORMATION PRESENTED IN THAT REPORT, I THINK THE RESPONSE IS INADEQUATE. WE NEED TO KNOW WHAT THE PLANS ARE TO DEAL WITH THE AGING VETERAN, AND WE NEED TO KNOW SOON, IF NOT TODAY. I HAVE SPOKEN OFTEN OF NON-INSTITUTIONAL ALTERNATIVES AS BEING ONE RESPONSE TO THIS IMPENDING PROBLEM. I WOULD LIKE THE PLANNERS AND BUDGETERS TO STOP THINKING OF THE NUMBER OF INPATIENTS TREATED AND AVERAGE DAILY CENSUS AS THE KEY INDICATORS OF VA BUDGET REQUIREMENTS. I WOULD LIKE TO SEE THESE PLANNERS' THINKING OF THE NUMBER OF VETERANS RECEIVING ADULT DAY HEALTH CARE, THE NUMBER RECEIVING HOSPITAL-BASED HOME CARE, AND THE NUMBER BEING CARED FOR AS OUTPATIENTS IN LIEU OF BEING HOSPITALIZED ALSO AS KEY INDICATORS. MR. CHAIRMAN, THE 21ST CENTURY IS CLOSER THAN WE THINK. THE TIME FOR ACTION AND DECISIONS ON HOW WE WILL MEET THE CHALLENGES FACING THE VA HEALTH CARE SYSTEM IS NOW.

THANK YOU MR. CHAIRMAN.



ALL MEDICAL PROGRAMS

ACTUAL VS. DEFLATED, BUDGET AUTHORITY

Statement of the Honorable Harry Walters
Administrator of Veterans Affairs

Mr. Chairman and Members of the Committee, I am pleased to appear before you today to testify in support of the Veterans Administration's fiscal year 1986 budget. This budget will allow us to continue to serve our Nation's veterans well.

As you know Mr. Chairman, this budget shows an effect of the President's emphasis on reducing the Federal deficit. However, you will find during this review of the budget, that the VA has fared very well in comparison to some other Departments of Government.

The total budget authority request for 1986 is $27.1 billion which consists of an appropriation request of $26.3 billion, $-61.8 million for proposed legislation and an estimate of $851 million through permanent authorizations. Increases in benefits for service-disabled compensation and pension beneficiaries and funding increases in Medical Care are more than offset by the 5 percent reduction in 1986 pay, implementation of third party reimbursements for medical insurance coverage, increased Loan Guaranty fees, and a reduction in construction funding.

Legislation is being proposed to eliminate medical care without regard to income levels for those veterans over 65 and make their eligibility the same as veterans under 65. Exempted from this reform would be service-connected veterans and certain categories of other veterans. This reform would restrict the use of the system by all non-exempt veterans whose income exceeds the eligibility level.

These higher income veterans would not be eligible for VA health care until their out-of-pocket medical expenses exceeded certain amounts. These amounts would be an increasing percentage from 25-90 percent of the amount that the veteran's income exceeded the eligibility level. This eligibility level would be set at twice the VA pension income standard. In emergency and extraordinary circumstances, veterans could receive care in the VA medical system by making their out-of-pocket contributions direct to the VA for the medical care received. In rare and exceptional circumstances, the VA Administrator could waive the veteran's expected medical expense contribution.

We are also planning to build on the mission and goals which the Department Heads and I established shortly after I joined the VA. Agency-wide we are beginning the pursuit of a cost saving ADP and Telecommunications modernization goal as a major element of our management goal. The thrust of that goal will be to provide better service to the veterans through the increased use of modern ADP and telecommunications technologies. I will be sharing with you over the next several months more detailed information about this goal and the objectives that support it.

I will now highlight the VA's request for major accounts.

Compensation

The appropriation request for this account is $10.2 billion. This amount is based on an estimated caseload of 2.2 million veterans which is a slight decrease from 1985 and 335 thousand survivors - a decrease of 4,100 from 1985. A rate increase of 4.1 percent, effective December 1, 1985, at a cost of $342.8 million also is included under proposed legislation. A December 1, 1984 rate increase of $263.4 million is being met primarily with a supplemental appropriation request of $175 million. Lower caseloads in both Compensation and Pensions allow the remaining costs to be met with existing funding.

Pensions

The Pensions caseload will continue to decrease in 1986. Current estimates indicate the veterans caseload will decrease by 34 thousand to 676 thousand while the survivors caseload will decrease by 64 thousand to 711 thousand. However, total budget authority shows an increase of $26.6 million to $3.8 billion due to an anticipated automatic cost-of-living increase of 4.1 percent effective December 1, 1985.

Burial Benefits and Miscellaneous Assistance

A budget authority increase of $2.8 million to $136.8 million is requested. This increase reflects the higher mortality rate of the aging veteran population.

Readjustment Benefits

An appropriation in excess of $1 billion is requested for 1986. This request, a decrease of $156 million from the 1985 request, shows the continued decrease of trainees as more veterans pass their 10 year delimiting date or attain their educational objectives. A 1985 supplemental appropriation of $44.2 million is requested to fund the 10 percent rate increase effective October 1, 1984.

Loan Guaranty

This request includes $404.6 million to help fund obligations of $1.91 billion. Estimated obligations for 1986 are $419 million less than the 1985 estimate. The Deficit Reduction Act of 1984 requires the VA to acquire properties under certain conditions. This Act also raised the 1/2 percent loan origination fee to a one percent loan origination fee on all loans. Revenue from this loan origination fee is to be deposited into the Loan Guaranty Revolving Fund to offset required obligations.

The Administration will request, under proposed legislation, an increase in this loan origination fee from the current one percent to five percent on both guaranteed and vendee (direct) loans. The vendee (direct) loan purchaser will have the option of paying the five percent loan origination fee or a one percent loan origination fee and a minimum of 5 percent down payment with a purchase of private mortgage insurance. If these initiatives are converted into public law, the fees will preclude the need for the $404.6 million budget authority request. This request clearly reflects the Administration's policy to require those receiving federal loan guarantees to pay for part or all of the expected federal default liability on the guaranteed loans.

Legislation also will be proposed to repeal the current authority to establish the maximum interest rate and instead allow negotiated rates between borrowers and lenders.

General Operating Expenses

The budget request for General Operating Expenses is $749 million and 18,681 average employment for the operations of the Department of Veterans Benefits, the Department of Memorial Affairs, and the various staff functions of our Central Office.

On February 11, 1985 a meeting was held between the VA Administrator and the Deputy OMB Director. At that time it was agreed that VA would develop a plan for modernizing its entire operations and will be considering various efficiency alternatives, one of which will be DVB consolidation. This effort has just begun and, when it is completed, a decision will be made as to the best course of action to be taken concerning DVB.

The Department of Memorial Affairs shows a request of 1,161 FTEE which is a reduction of 57 below the 1985 level. This reduction will be achieved by contracting various activities at national cemeteries. It is expected that total interments will increase by 6 percent, gravesites maintained will increase by 2.5 percent, and headstone/marker applications processed will be 2.7 percent over 1985 levels.

In the General Administration activity, 1986 funding and FTEE will be reduced below the 1985 estimates by $680,000 and 154 FTEE, respectively. The FTEE reductions will be achieved through improved productivity and efficiencies in operations which will not reduce services provided. To assist in this effort, $2 million is included for office automation which is expected to yield productivity improvements in 1986 and the future. Within the data processing activity, several facilities will close with those functions consolidated at the primary data processing centers in Hines, Illinois and Austin, Texas. The closure of the St. Paul and Los Angeles data processing centers, and the Romney, West Virginia message switching center will result in average employment requirements being reduced by 113.

Medical Care

The Medical Care appropriation request for 1986 is $9.1 billion, an increase of $235.6 million over the 1985 level. Average employment is projected to increase by 199 over an adjusted 1985 employment level of 191,849. The number of inpatients treated is projected to increase by 3,211 to a level of 1.4 million, and outpatient medical visits will increase by 112 thousand to a level of 18.8 million. The increased resources also will provide partial year activation resources for the replacement hospital at Portland, Oregon, replacement and modernization of clinical services at Albuquerque, New Mexico, and expansion of clinical, outpatient and administrative facilities at Birmingham, Alabama. One new satellite outpatient clinic will be activated.

The 1986 request also provides for new or expanded initiatives in the areas of: the Integrated Hospital System, Occupational Safety and Health program and a physical fitness program for the disabled/handicapped.

In addition, legislation will be proposed to obtain reimbursement from third party insurance carriers for the cost of medical care and treatment to non-service-connected veterans.

MEDICAL AND PROSTHETIC RESEARCH

The 1986 total request for Medical and Prosthetic Research of $187.1 million and 4,348 FTEE. The 1986 requirements for the Agent Orange Epidemiology Study being conducted by the Centers for Disease Control is $3.8 million. Research support will continue in the ongoing high priority research programs in Agent Orange, aging, health of former Prisoners of Wars, alcoholism, health problems of female veterans, spinal cord injury, delayed stress disorders, cancer, preventive health, and prosthetic/sensory aids. Because of their high priority, no FTEE reduction is planned for Prosthetic Research and Health Services Research.

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES

The 1986 request for this program is $55.9 million and 753 FTEE. These amounts reflect the effects of the 5 percent government-wide pay reduction, the GS/GM 11-15 grade reduction excluding Title 38 employees, a 10 percent administrative reduction and the phasing out of the Health Professional Scholarship Program.

Construction

The 1986 request for the two construction appropriations totals $611.6 million. An additional $160 million, available from previous appropriations, will contribute toward a total program level of $771.6 million. Included is $712.9 million for medical facility projects, $18.9 million for the National Cemetery program, $2.0 million for the Department of Veterans Benefits Regional Office program, $2.0 million for the Office of Data Management and Telecommunications, $500,000 for the year old Emergency Fund, and $35.3 million for General Administration.

There are 33 projects in the major projects construction request. Initial construction funding is requested for Philadelphia, Pennsylvannia; funding for the main hospital building for Houston, Texas, and renovations and replacement of buildings in Mountain Home, Tennessee also is requested. The major construction request for the National Cemetery Program is $12.5 million; $6.5 million is requested to provide for construction in Florida and $6 million is requested for a land acquisition in Northern California for a National Cemetery. The construction program also continues to emphasize the correction of life safety and other code deficiencies. Two new nursing homes are scheduled for construction in Amarillo, Texas and Tucson, Arizona.

This concludes my prepared statement, Mr. Chairman. My staff and I will be pleased to answer your questions regarding the 1986 budget estimates of the Veterans Administration.

REDUCTION OF OPERATING COSTS
OFFICE OF DATA MANAGEMENT AND TELECOMMUNICATIONS

Introduction

The President has called upon all Executive Agencies to develop ways to reduce government costs by making government operations more efficient and effective. The Veterans Administration has proposed a Fiscal Year 1986 budget which strives to improve our efficiency in delivering benefits and services to veterans and eligible dependents. As a consequence, we in the Office of Data Management and Telecommunications have been challenged to review our operations and develop more cost-effective means to provide the current level and scope of services without impairing the mission of the Agency. In response to this need, the Agency has proposed consolidating activities from the Los Angeles and St. Paul Data Processing Centers (DPCs) to DPCs at Austin, Hines and Philadelphia and the Romney, West Virginia, VADATS Message Switching Center (MSC) to the Austin MSC.

Objective

To provide the existing level of ADP support for veterans' programs at lower cost to the government.

Background

A review of ODM&T operating costs reveals that two major categories of cost are incurred on an annual basis. These costs are for personnel and technology. Personnel costs are primarily salary costs for FTEE resources. Technology costs include purchase, rental and maintenance of equipment, facility rent and maintenance, and other similar services. Both personnel costs and technology costs must be considered when reviewing alternatives to provide existing services with fewer dollars.

Cost Reduction Methods

There are three major avenues to reduce operating costs of VA ADP and telecommunications services, without adversely affecting the delivery of services to veterans. These are:

(1) improved productivity and contracting out where appropriate (A-76);

(2) attrition of on-board staff to realize the benefit of productivity gains and reduce FTEE costs to the VA; and

(3) the consolidation of current activities to achieve both FTEE and technology cost reductions.

Current plans include using all three approaches to reduce the cost of ODM&T operations. Each is examined further in the context of the present operating environment.

(1) Productivity Reviews and Contracting Out:

The VA has established a plan for productivity reviews and A-76 studies for its ADP and telecommunications activities. The earliest productivity reviews are to be completed in the third quarter of Fiscal Year 1986, and the earliest cost studies are to be completed in the first quarter of Fiscal Year 1987. None of these will identify potential cost-savings until late Fiscal Year 1987. They may not be accelerated because of the complex procedures for conducting the A-76 studies and procurement actions. Contracting out will not reduce operating costs by any significant degree until Fiscal Year 1988 and beyond. A summary of the scheduled activities in the VA plan is as follows:

OMB Circular A-76 Productivity Improvement Program Review Schedule

	FY 1985				FY 1986				FY 1987				FY 1988			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Austin DPC					x	x	x	x	x	x	x	x	x	x		
Hines DPC			x	x	x	x	x	x	x	x	x	x	x	x		
Philadelphia DPC							x	x	x	x	x	x	x	x	x	
St. Paul DPC								x	x	x	x	x	x	x	x	x
Los Angeles DPC									x	x	x	x	x	x	x	x

(2) Attrition of Existing Staff

Attrition is the reduction of FTEE costs achieved by not filling vacancies created by employees who leave ODM&T.

ODM&T currently experiences an attrition rate of 300 technical FTE per year. While the attrition rate would seem to result in a significant reduction of FTEE in nine months, there are several critical issues that make this unlikely.

First, with declining numbers of government ADP jobs available, it is not clear that the rate of attrition will continue at that level. A large amount of current ODM&T attrition is caused by movement of employees to other federal agencies.

Second, ODM&T services are provided from seven operational centers around the country. With over 100 job classifications for highly specialized ADP and telecommunications skills and the numbers of operational elements required to provide around the clock computer services, many technical staffs are already very small and a one FTEE reduction may amount to one-fourth of the staff. Most of those staffs could not be reduced without disrupting operations or services. Frequently, the more highly skilled (and mobile) employees must be replaced in order to assure technical direction of the less skilled, and maintain complex operations. Skills of a computer operator, data technician, and management analyst are not interchangeable; retraining and development cannot be quickly or cheaply accomplished.

Third, based on the expected Fiscal Year 1986 3.5% salary shortfall because of the Fiscal Year 1985 pay raise, ODM&T may have to use attrition to reduce an additional 65 FTEE by the end of Fiscal Year 1985.

We don't believe that ODM&T can maintain the administrative and operational FTEE overhead associated with seven separate operational sites. Thus, attrition does not seem to be a viable alternative. This conclusion is further reinforced by the significant potential outyear FTEE reduction projected for productivity reviews and contracting out activities.

It would be easy to assume that a significant reduction of staff could be accomplished via attrition were it not for the highly specialized skills and relatively small numbers of FTEE providing specific areas or types of service. In many cases, the individual technical skills are unique to a specific operation, a specific service or a specific application system. An analyst cannot be as equally competent on several applications as on one, nor can the existing level of support be provided by fewer analysts. The same is generally true of other specialized skills.

An analysis of the skills and job titles of the Fiscal Year 1984 losses, and the location where the losses occur, indicates clearly that the loss pattern does not match the staffing requirements of the current workload. In order to effectively and efficiently operate a data processing center, develop essential new applications, enhance existing applications, maintain the many other system applications, and produce the required output products, replacement of losses in the critical support areas is essential to success. The turnover rate at our five data processing centers varied from a low of 9.6% to a high of 71.8% for Computer Programmers. The rate for Computer Analysts/Specialists varied from a low of 9.7% to a high of 100%; the rate for Computer Operators ranged from 4.5% to 20%; the rate for Data Transcribers ranged from 4.8% to 100%. The overall loss ratio at these sites varied from a low of 16% to a high of 31.8%. These wide variances in the turnover (loss) rates at the data processing centers and within the various job categories at each site preclude the use of normal attrition to reach lower staffing levels, and still provide the same level of ADP and telecommunications service required by VA departments and staff offices. Attrition could only be permitted where the services provided are performed more efficiently or with lowered overhead. Our ongoing work measurement studies lead to the conclusion that very small reductions in FTEE costs may be realized, and this avenue will be pursued through productivity reviews.

(3) Consolidation of ODM&T Activities:

The consolidation approach includes reviewing of existing ODM&T activities to ascertain what efficiencies and savings may be achieved through combining similar activities and eliminating overhead costs where possible.

In order to significantly reduce Fiscal Year 1986 operating costs, both FTEE and technology costs must be reduced by October 1, 1985. ODM&T facilities differ significantly in size and scope of operations. This affects how consolidations may be considered in order to reduce costs.

The matrix below identifies key factors to be considered and their relative degree of impact among the existing activities:

Facility	Nos. of FTEE	Application/ Service Transportability	Current Cost Per Sq. Ft.	Potential Personnel Costs of Moving Activity	Cost to Replace Facility	Cost to Relocate Equip.
Austin	588	Complex	Moderate	Very High	High	High
Hines	406	Very Complex	Low	Very High	High	High
Phila.	190	Complex	Moderate	Moderate	Moderate	High
St. Paul	115	Simple	High	Moderate	Low	Low
L.A.	43	Simple	Very High	Low	Low	Low
Romney	30	Simple	High	Low	Low	Low

An examination of this matrix based upon existing operating costs and expectations reveals relatively higher unit costs for the smaller facilities. This is true in potential FTEE costs to achieve consolidation, in potential disruption of services, in facility costs, in costs to replace existing facilities at another location, and in the projected costs to relocate and operate existing equipment. Among the smaller four facilities, only the Philadelphia services could not be provided from another location at present. This is because the presently used technology requires the co-location of the computer system and users. The services provided by St. Paul, Los Angeles and the Romney MSC can be provided from other locations without adverse impact on veterans' programs.

Specifically, the benefits of consolidation would appear to include the closing of the Los Angeles and St. Paul Data Processing Centers (DPCs) and the Romney MSC. By transferring equipment, applications, and limited FTEE to remaining DPCs, this option would result in approximate FTEE savings of 38 from Los Angeles DPC, 58 from the St. Paul DPC and 17 from the Romney MSC for a total permanent reduction of 113. At each location, the FTEE savings is a direct result of the fact that certain work currently performed at each location is already being performed at the facility of consolidation. To illustrate, an existing computer shift operation does not necessarily require additional FTEE because additional application programs are added to the workload. Essentially, the consolidation is in large part a decrease of workload at the losing site with an equivalent increase at the new location. To a great extent this increased workload can be handled with no supplement in staffing levels and no adverse impact on level of service. The consolidation of our operations will provide the existing level and schedules of services to VA organizations, and permanently reduce the overhead associated with maintaining the three facilities.

The specific implications of consolidation for each facility include:

Los Angeles DPC

Closing the Los Angeles DPC and moving the service activities to the Hines DPC would entail the following: move all hardware and software from Los Angeles to Hines; move communications circuits from an endpoint in Los Angeles to an endpoint in Hines; and move six FTEE from Los Angeles to Hines. This would reduce total FTEE by 38 from the present 44 in Los Angeles.

Only six FTEE would be required to bolster the existing Hines technical staff, because of the similarity in operation between the two sites. The increased computer workload would produce only a fractional increase in the total workload. No retraining would be involved because personnel would be performing the same tasks at Hines.

St. Paul DPC

Closing the St. Paul DPC and moving the service activities to the Austin DPC would involve the following: move the software and certain of the hardware from St. Paul to Austin and Philadelphia; and move 57 FTEE from St. Paul to Austin. This would reduce total FTEE by 58 from the present 115 in St. Paul.

The 57 positions, primarily applications programmers and auditors, are needed at the Austin DPC to support the transferred workload. It is also estimated that Austin can absorb some additional operational workload within their existing personnel resources. Minimal retraining would be involved in the relocation.

VADATS Romney Message Switching Center

Consolidate the ADP/message functions of both Romney and Austin MSCs at the Austin MSC. Minimal equipment movement is required. No augmentation of the Austin MSC staff is required, which would reduce MSC operations by 17 FTEE.

While there are anticipated Fiscal Year 1986 closing costs, this approach achieves a permanent reduction of 113 FTEE and a part of the operating budget for each of the closed facilities. Cost savings will begin to be realized in Fiscal Year 1986. The costs would appear to be recovered in less than two years through reduced salary and operating costs for ODM&T.

A summary of the cost-savings to the government based upon current estimates are as follows:

Estimated Consolidation Dollar Savings Per Year

	Personal Services	Space	Telephone(1)	Blg Maint.	Total
St. Paul	1,522,000	799,000(2)	42,000	8,000	2,371,000
L.A.	1,108,000	1,106,000(2)	56,000	29,000	2,299,000
Romney	448,000	220,000(3)	1,000	(4)	668,000
	3,078,000	2,125,000	99,000	37,000	5,338,000

(1) Local Telephone Only
(2) Begin in 1987
(3) Begin in 1988
(4) Included in Space

Summary

Three alternatives are being used to reduce ODM&T operating costs. Productivity reviews and potential contracting out of ODM&T activities are expected to produce results in Fiscal Year 1988 and beyond. Attrition is expected to be used in Fiscal Year 1986 and beyond to translate productivity gains into cost savings. Independent of the preceeding activities, consolidation of ODM&T activities will reduce operating costs in Fiscal Year 1986 and beyond. The basis for consolidation is generally as follows:

There are five DPCs operated by the Agency. Based upon budgetary and managerial consideration, the consolidation of activities is seen as necessary. It is not economically feasible to consider consolidating the very large operations at Hines and Austin to other locations, nor is it practical or feasible to relocate the insurance activities from Philadelphia.

(1) St. Paul is a relatively small operation dedicated primarily to CARS (Centralized Accounts Receivable System) support. The operation is configured for remote site processing and can be relocated easily, compared to other alternatives.

(2) The Los Angeles DPC performs functions compatible with other locations which could absorb this workload. Additionally, the operating and overhead costs in Los Angeles are comparatively high, and relocation of this facility will attain a savings greater than its proportionate size.

(3) The Romney operation is compatible with functions performed at Austin. It will be more efficient to combine these like functions, and the logical proposal is to shift the workload to the major network user which is the Austin DPC.

To implement the consolidation, a detailed technical and logistical consolidation plan is being developed. The VA will meet all labor-management obligations and will offer available relocation opportunities to the affected employees, as well as establish an aggressive placement assistance program to ensure that they receive consideration for all suitable vacancies within the Agency. We will also establish referral contracts with other Federal agencies, State and local government and private sector organizations.

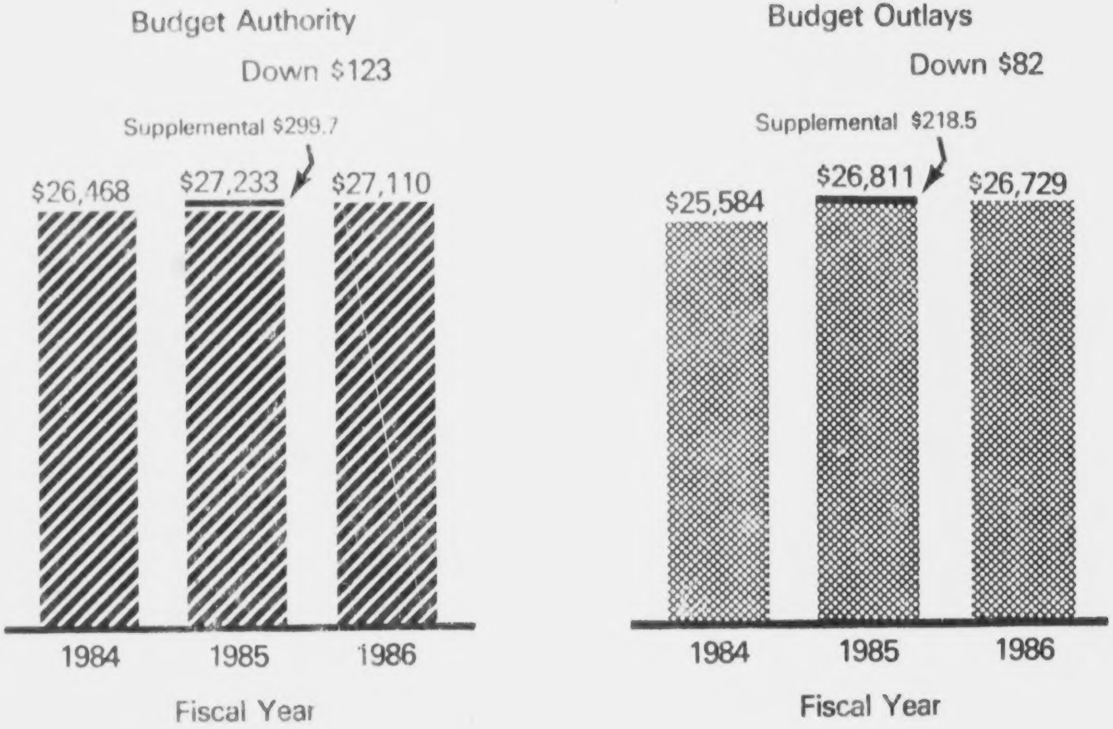
Veterans
Administration

FY 1986 Budget

Director, Office of Budget and Finance (Controller)

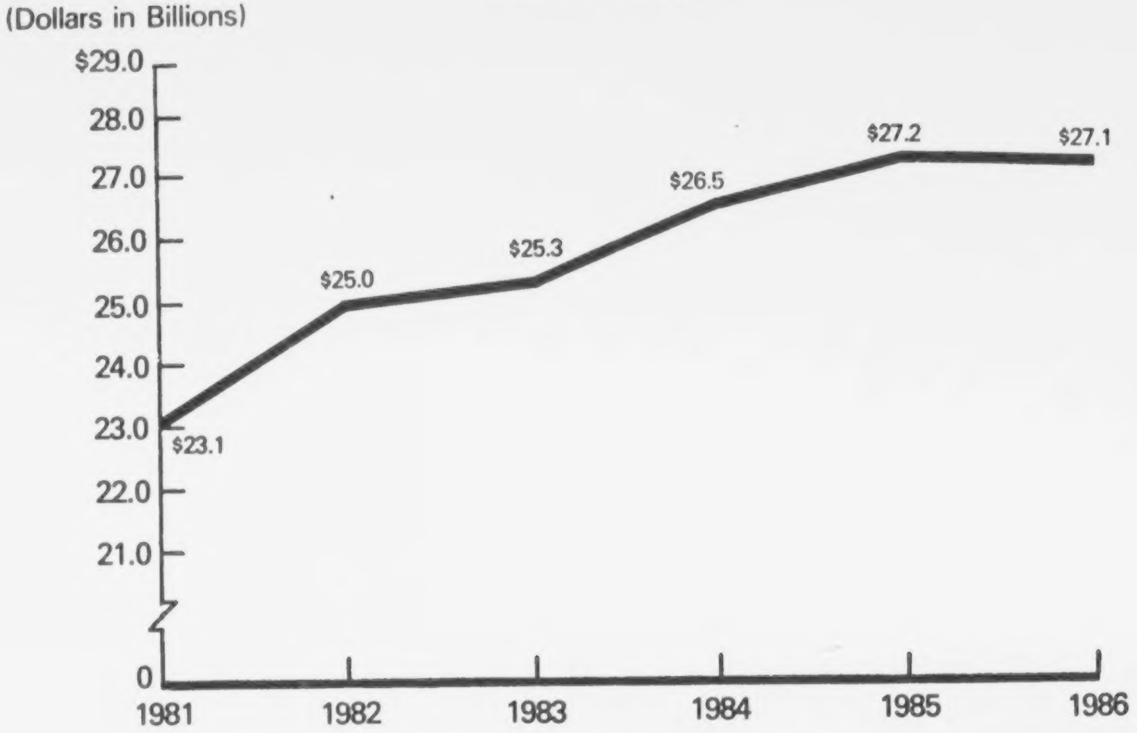
FY 1986 Budget

(dollars in millions)

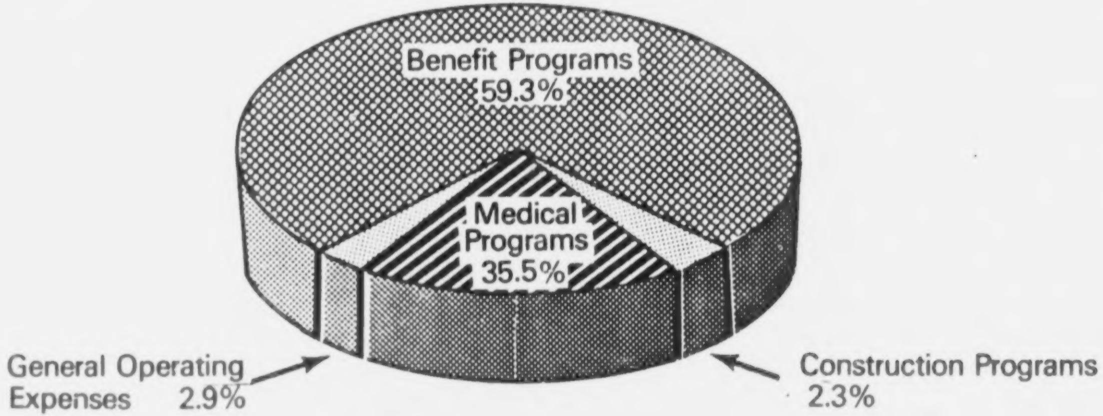


Total Budget Authority

1981 - 1986



1986 Appropriation Request



Distribution by Major Programs
(dollars in millions)

Benefit Programs	$15,601	59.3%
Medical Programs	9,355	35.5%
Construction Programs	612 *	2.3%
General Operating Expenses & Miscellaneous	752	2.9%
Total, VA	$26,321	

* *Program Level $772 million.*

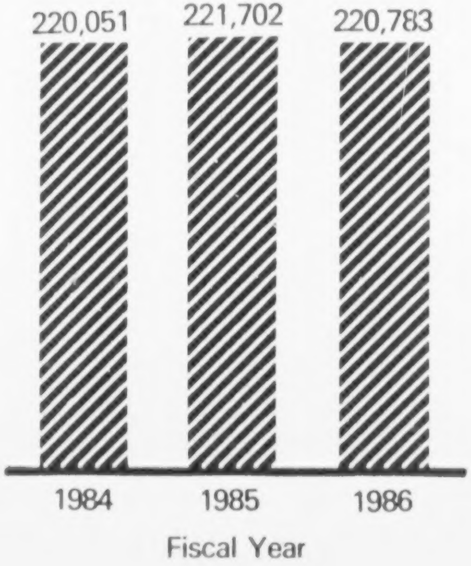
1986 Budget Authority Requiring Action by Congress:

(dollars in millions)

APPROPRIATIONS REQUEST (EXISTING LEGISLATION)	$26,321
PROPOSED LEGISLATION	-62
TOTAL - REQUIRING ACTION BY CONGRESS	$26,259
PERMANENT AUTHORIZATIONS AND OFFSETTING RECEIPTS	916
PROPOSED LEGISLATION	-65
TOTAL, BUDGET AUTHORITY	$27,110

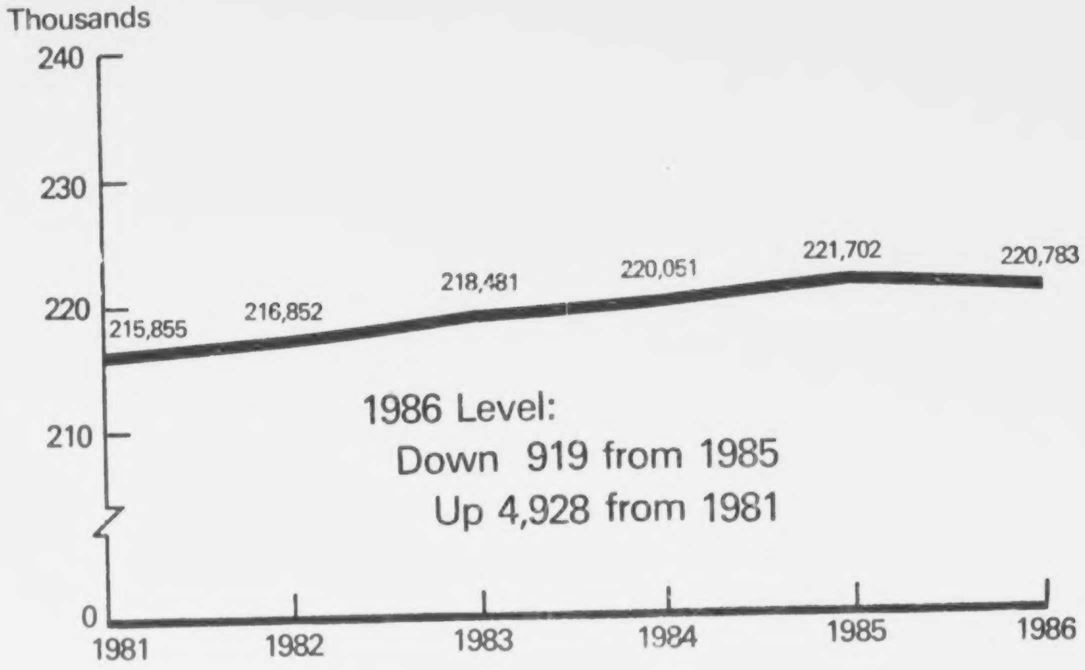
Average Employment

Down 919



Dept. of Medicine and Surgery	– 42
Dept. of Veterans Benefits	– 624
Dept. of Memorial Affairs	– 57
Office of Construction	– 30
General Administration (GOE)	– 154
Supply Fund	– 12
	– 919

Total Average Employment



FY 1985 Supplemental Requirements

(dollars in thousands)

	PROGRAM SUPPLEMENTAL	PAY RAISE SUPPLEMENTAL	TOTAL SUPPLEMENTAL
COMPENSATION	$175,000	...	$175,000
READJUSTMENT BENEFITS	44,200	...	44,200
MEDICAL CARE	...	$72,524	72,524
GENERAL OPERATING EXPENSES	...	7,932	7,932
CONSTRUCTION, MINOR[1]	...	(371)	...
TOTAL	$219,200	$80,456	$299,656

[1] Limitation Increase Only.

FY 1985 Rescission Proposals

(dollars in thousands)

	AMOUNT	FTEE
MEDICAL CARE	$-10,261	-133
MEDICAL AND PROSTHETIC RESEARCH	-323	...
MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES	-2,109	...
GENERAL OPERATING EXPENSES	-4,334	- 5
CONSTRUCTION, MINOR	-377	...
TOTAL	$-17,404	-138

Proposed Legislation

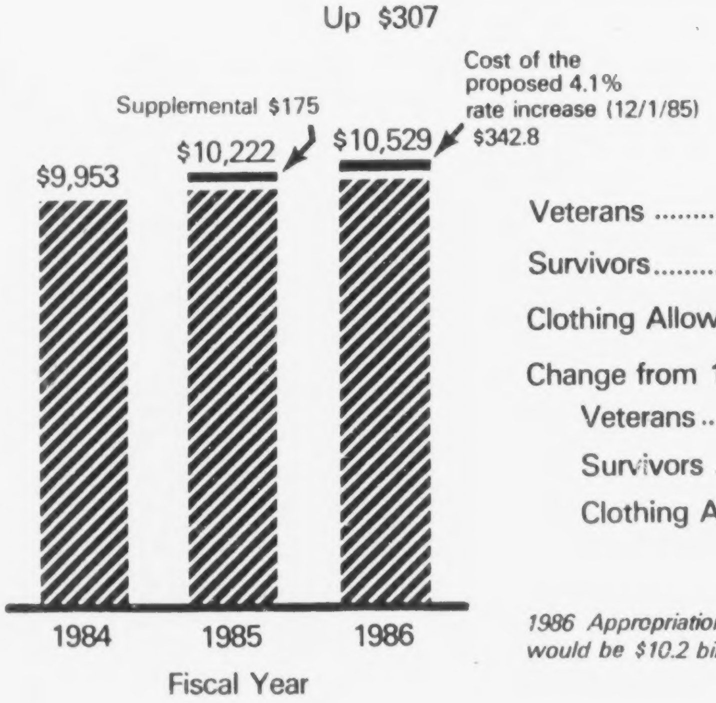
(dollars in thousands)

	1986
COMPENSATION:	
● 4.1% FY 1986 RATE INCREASE (12/1/85)	$342,800
LOAN GUARANTY:	
● LEGISLATIVE INITIATIVE TO INCREASE LOAN ORIGINATION FEE FROM 1 PERCENT TO 5 PERCENT ON ALL GUARANTEED AND VENDEE LOANS	-404,600
PROPRIETARY RECEIPTS:	
● REIMBURSEMENT FROM THIRD PARTY INSURANCE CARRIERS (10/1/85)	−65,000
	$-126,800

NOTE: THE ADMINISTRATION WILL ALSO PROPOSE LEGISLATION TO ESTABLISH A MEANS TEST FOR CERTAIN CATEGORIES OF VETERANS WITHOUT SERVICE-CONNECTED DISABILITIES WITHOUT REGARD FOR AGE.

Compensation

(dollars in millions)

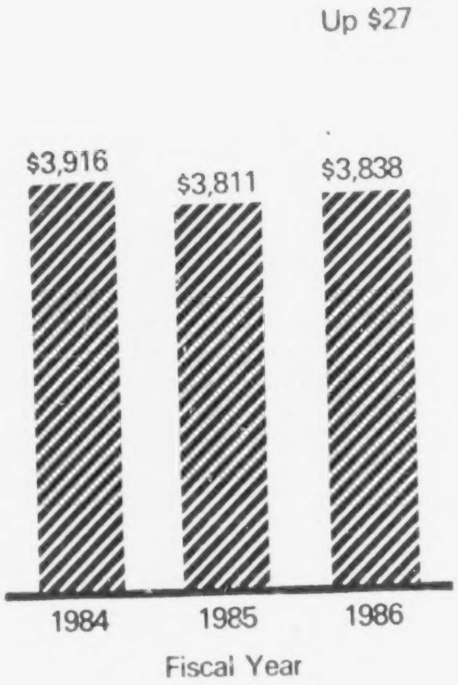


	Caseload	Average Payment in Whole Dollars
Veterans	2,227,100	$ 3,687
Survivors	335,000	5,827
Clothing Allowance	66,400	349
Change from 1985:		
Veterans	− 15,900	− 6
Survivors	− 4,100	+ 92
Clothing Allowance	− 100	+ 1

1986 Appropriation without the rate increase would be $10.2 billion.

Pensions

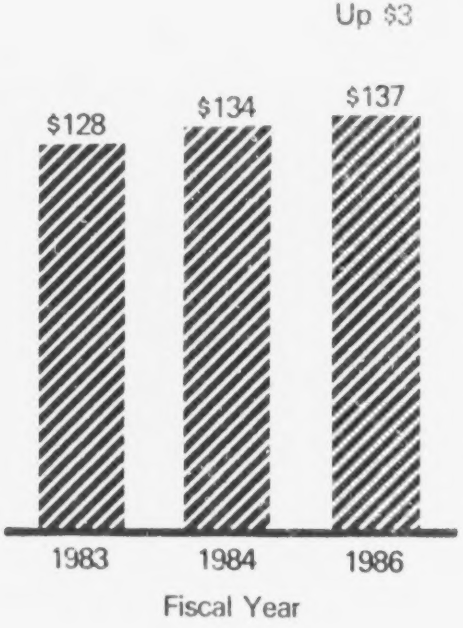
(dollars in millions)



	Caseload	Average Payment in Whole Dollars
Veterans	676,100	$ 3,771
Improved Law	420,300	5,116
Prior Laws	255,800	1,565
Survivors	710,900	1,809
Improved Law	249,600	3,565
Prior Laws	461,300	860
Vocational Training	(1,600)	(1,125)
Total	1,387,000	2,767
Change from 1985:		
Veterans	– 34,500	$ + 203
Survivors	– 64,500	+ 116
Vocational Training	(+800)	(+ 375)
Total	– 99,000	+ 177

Burial Benefits and Miscellaneous Assistance

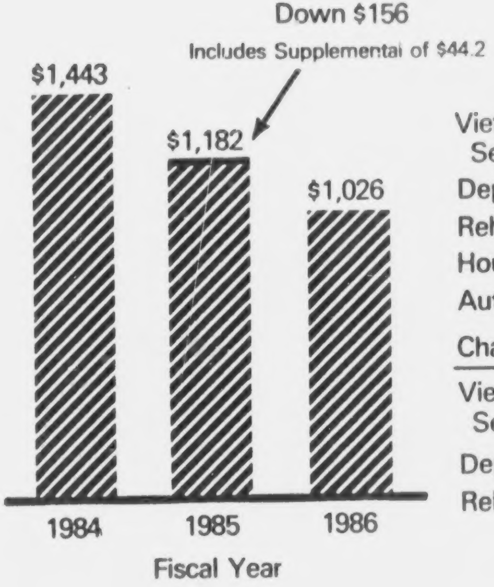
(dollars in millions)



	Caseload	Average Payment in Whole Dollars
Burial Allowances	121,000	$365
Burial Plots	341,000	150
Burial Flags	360,000	25
Mortgage Insurance	5,920	743

Readjustment Benefits

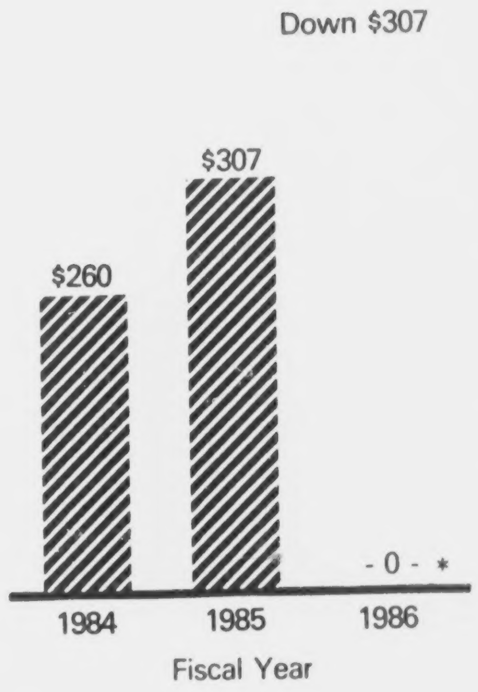
(dollars in millions)



	Caseload	Average Payment in Whole Dollars
Vietnam Era Veterans & Servicepersons	342,700	$ 2,223
Dependents	54,300	2,414
Rehabilitation	28,400	4,069
Housing Grants	405	30,765
Auto Grants	650	5,000
Change from 1985:		
Vietnam Era Veterans & Servicepersons	– 82,500	$ – 1
Dependents	– 7,300	+ 2
Rehabilitation	– 800	+ 61

Loan Guaranty

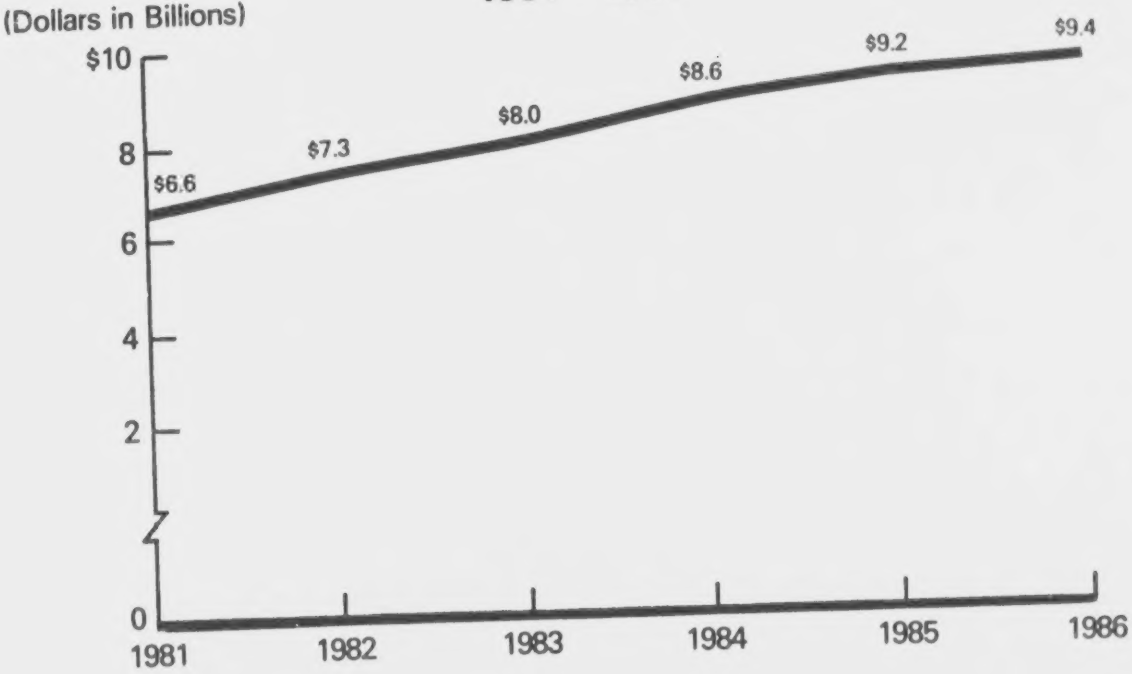
(dollars in millions)



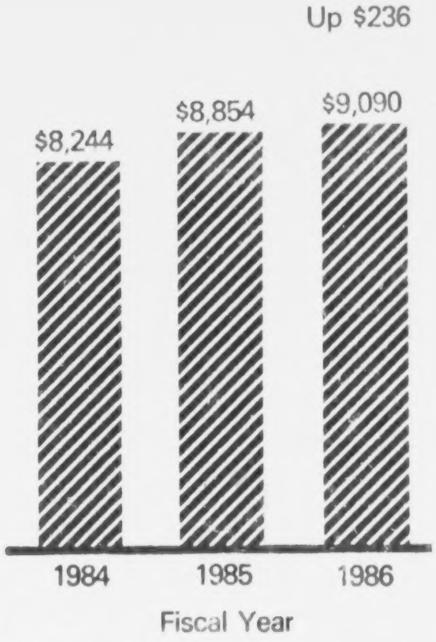
	Caseload	Change from 1985
● Claims Processed	22,600	– 4,000
● Property Acquisitions Processed	16,640	– 4,960
● Property Sales	19,400	– 5,135
● Property Inventory (Avg.)	18,658	– 1,872

* *Legislation will be proposed to increase loan origination fee from 1 percent to 5 percent and eliminate funding requirement. If this legislation is not enacted the 1986 requirement will be $404.6 million.*

Total Medical Programs
Budget Authority
1981 - 1986



Medical Care
(dollars in millions)



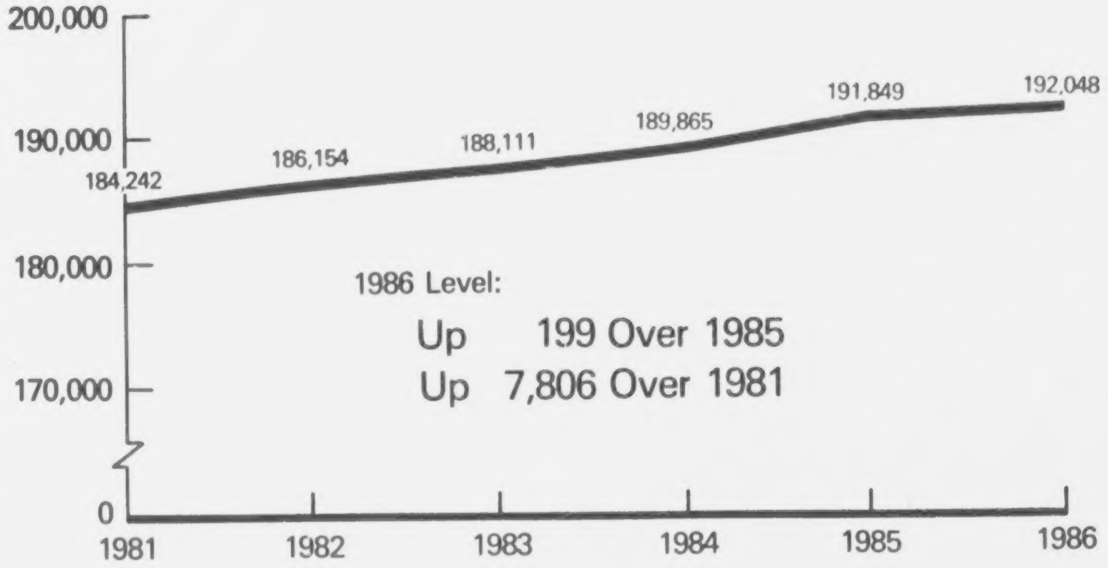
Average Employment Up 199 to 192,048

Funding up $236 million:	FTEE	AMT
● Normal Payroll Increases	. . .	$+207
● Inflation	. . .	+182
● Activations and Capital Investment	+2,068	+103
● Other Program Improvements	+ 189	+ 13
● Workload Related Changes	− 142	+ 2
● Government-wide and Management Reductions:		
- Five Percent Pay Reduction	...	− 203
- Management Reductions	−1,916	− 68

Provides For:

- 204 Hospital to Nursing Home Bed Conversions
- VA Physical Fitness Program
- 3,211 Patients Treated Increase
- 112,000 Outpatient Visits Increase

Medical Care
Average Employment



1986 Level:

Up 199 Over 1985
Up 7,806 Over 1981

VA Nursing Home Activations

FY 1985:

	BEDS
BOISE, IDAHO	60
BRONX, NY	120
DALLAS, TX	120
DENVER, CO	60
FRESNO, CA	60
MARION, IL	60
SEATTLE, WA	60
SPOKANE, WA	60
TAMPA, FL	120
WASHINGTON, DC	120
W. LOS ANGELES, CA	120

Operating Beds - Average

	VA HOSPITALS	VA NURSING HOMES	DOMICILIARIES
1981	82,100	8,700	8,400
1982	80,200	9,100	8,300
1983	79,800	9,400	8,200
1984	79,200	9,700	7,900
1985	78,600	10,800	7,500
Change	-1,000	+ 700	- 100
1986	77,600	11,500	7,400

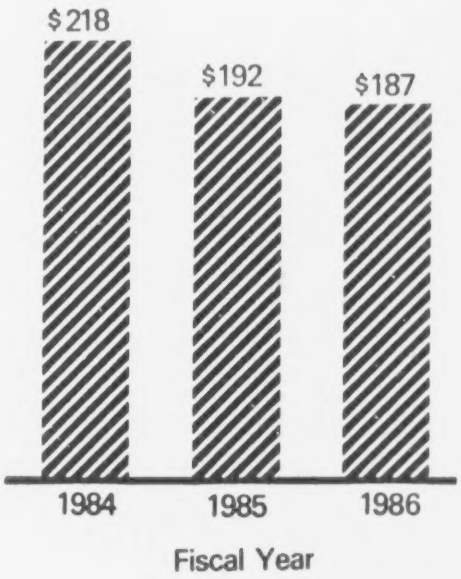
Key VA Medical Workloads

	INPATIENTS TREATED		VA NURSING HOME CARE PATIENTS	OUTPATIENT MEDICAL VISITS
	TOTAL BENEFICIARIES	VA HOSPITAL PATIENTS		
1981	1,360,000	1,249,000	14,000	17,932,000
1982	1,358,000	1,243,000	15,000	17,971,000
1983	1,401,000	1,280,000	16,000	18,519,000
1984	1,412,000	1,290,000	17,000	18,597,000
1985	1,406,000	1,280,000	18,000	18,685,000
Change	+ 3,000	---	+2,000	+ 112,000
1986	1,409,000	1,280,000	20,000	18,797,000

Medical and Prosthetic Research

(dollars in millions)

Down $5



Average Employment Down 157 to 4,348

Funding Down $5 Million	FTEE	Amount
● Medical Research	-157	$ −6.1
● Rehabilitation Research	...	+ .6
● Health Services	...	+ .2

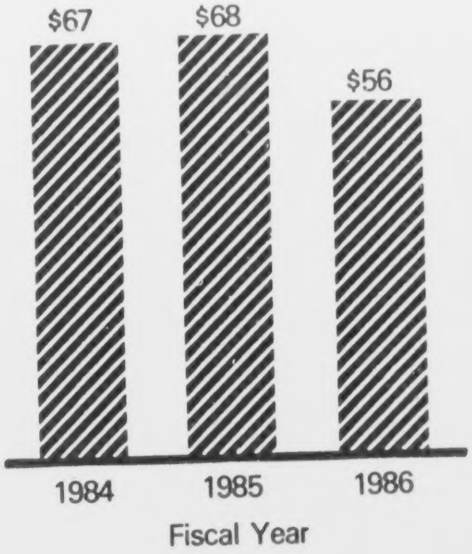
Maintain High Priority Programs:

- Support Agent Orange
- Aging
- Health of Former POW's and Female Veterans
- Alcoholism
- Post Traumatic Stress Disorders
- Spinal Cord Injury
- Preventive Health
- Prosthetics/ Amputations
- Molecular Medicine

Medical Administration and Miscellaneous Operating Expenses

(dollars in millions)

Down $12

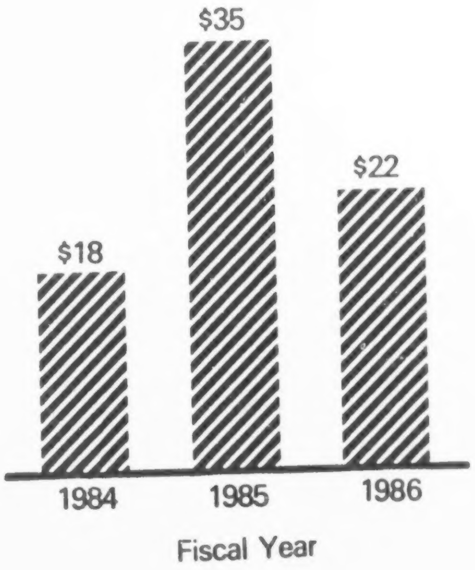


- Average employment Down by 84 to 753

	FTEE	AMT
● Funding Down $12 Million		
• Medical Administration	– 76	$ – 7
• Postgraduate & Inservice Training	. . .	– 1
• Health Professional Scholarships	– 8	– 4

Grants for Construction of State Extended Care Facilities

Down $13



Funding Down $13 Million

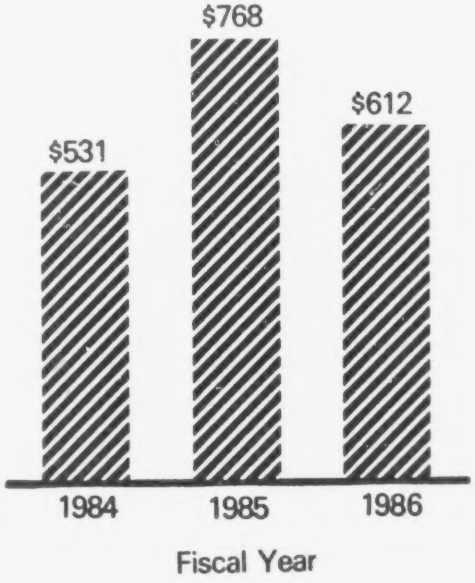
Provide for Additional:

- 450 Nursing Home Beds
- 126 Convertible (Domiciliary/Nursing Home) Beds

Construction Programs Summary

(dollars in millions)

Down $156



Average Employment at 810 (Down 30)

(Includes Purchase and Hire)

Program Funding:	Total	Change
● Medical Program	$712.9	$–154.9
● Cemetery Program	18.9	+ 1.8
● Veterans Benefits	2.0	– .8
● Emergency Fund	.5	– .5
● ODM&T	2.0	+ 2.0
● General Administration (710 FTEE Excluding P&H)	35.3	– 3.8
	$771.6	$–156.2

Medical Construction Program
(dollars in millions)

		FY 1986
REPLACEMENT AND MODERNIZATION		
● HOUSTON, TX	REPLACEMENT & MODERNIZATION	$190.0
● MOUNTAIN HOME, TN	BEDTOWERS & RENOVATION	59.0
● PHILADELPHIA, PA	CLINICAL ADDITION, RENOVATION, PARKING AND 240-BED NURSING HOME CARE UNIT	12.0
		$261.0
NURSING HOME CARE (NHC)		
● AMARILLO, TX	120 BED NHCU	$ 6.5
● TUCSON, AZ	120 BED NHCU	6.8
● MINOR PROJECTS.		10.0
		$ 23.3
DOMICILIARIES		
● TEMPLE, TX	408-BED REPLACEMENT DOMICILIARY	$ 17.3
● WOOD, WI	RENOVATE BUILDING 43 FOR DOMICILIARY	6.4
		$ 23.7
CLINICAL IMPROVEMENTS		
● BIG SPRING, TX	RENOVATE SURGERY	$ 3.7
● TOGUS, ME	CLINICAL IMPROVEMENTS BUILDING 200	30.7
● MINOR PROJECTS		18.0
		$ 52.4

Medical Construction Program

(dollars in millions)

	FY 1986
OTHER IMPROVEMENTS	
● ADVANCE PLANNING FUND	$ 19.0
● ASBESTOS ABATEMENT	35.0
● DESIGN FUND	20.0
● ELECTRICAL IMPROVEMENTS	11.4
● FIRE AND SAFETY IMPROVEMENTS	42.2
● MISCELLANEOUS PROJECTS	74.2
● SEISMIC	26.2
● ENERGY CONSERVATION	4.2
	$232.2
GENERAL PROJECTS	$130.3
SUBTOTAL	$722.9
LESS: FY 1985 DESIGN FUND	-10.0
TOTAL, MEDICAL CONSTRUCTION PROGRAM	$712.9

Veterans Benefits Construction Program
(dollars in millions)

	FY 1986
● MINOR PROJECTS	$ 2.0

Cemetery Construction Program
(dollars in millions)

● FLORIDA	DEVELOP 13,000 GRAVESITES AND CONSTRUCT ADMINISTRATION BUILDING	$ 6.5
● NORTHERN CALIFORNIA	LAND PURCHASE	6.0
● MINOR PROJECTS		6.4
		$ 18.9

Computer Centers
(dollars in millions)

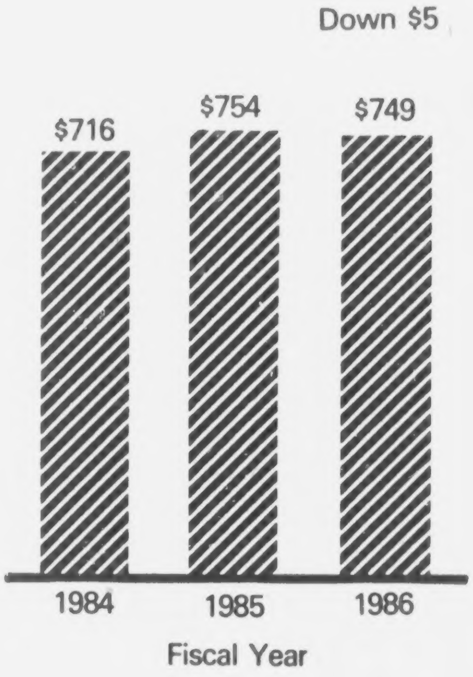
● MINOR PROJECTS	$ 2.0

Emergency Fund
(dollars in millions)

● MINOR PROJECTS	$ 0.5

General Operating Expenses

(dollars in millions)



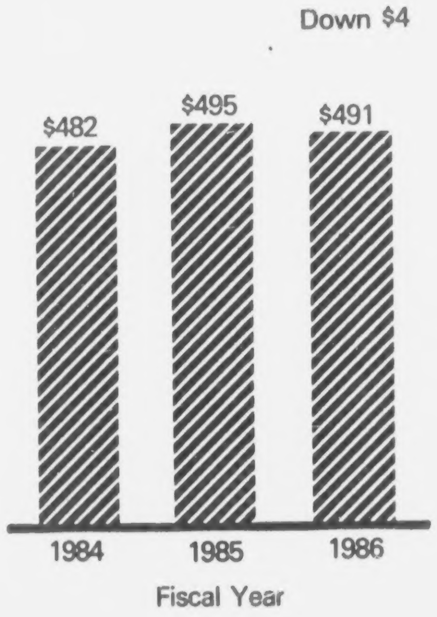
Average Employment Down 835 to 18,681

Major Funding Changes:

● Veterans Benefits	$ – 4.1
● Memorial Affairs	+ 0.1
● General Administration	– 0.7

Department of Veterans Benefits

(dollars in millions)



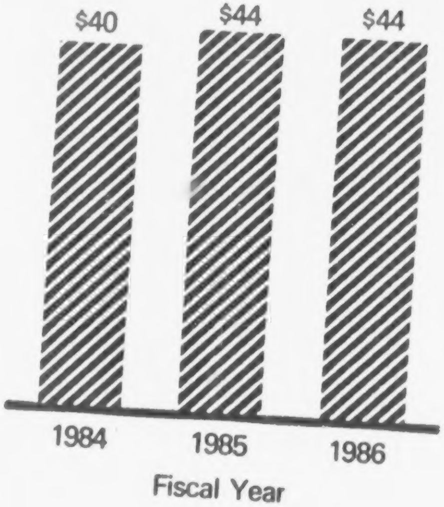
Average Employment Down 624 (13,518 to 12,894)

Major Funding Changes:

● Savings Through Consolidation (−624 FTEE)	$ − 15.6
● First Year Costs of Consolidation	+ 25.1
● Five Percent Pay Reduction	− 12.3
● State Approval Agency and Reporting Allowance Payments	− 2.3
● All Other (Net)	+ 1.1

Department of Memorial Affairs

(dollars in millions)



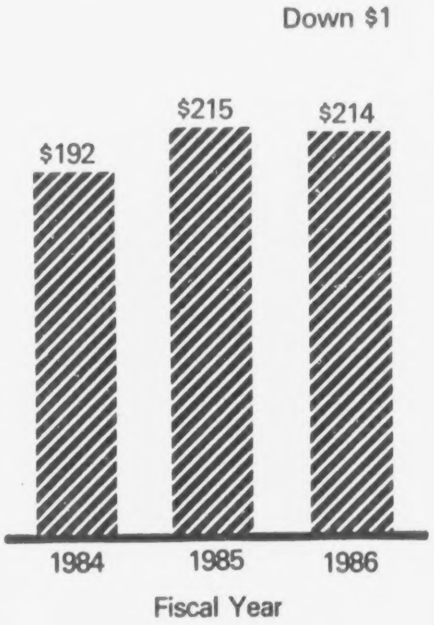
Average Employment Down 57 (1,218 to 1,161)

Major Funding Changes:

● Cemetery Expansion (Bay Pines, FL, Ft. Mitchell, AL) and Workload Growth (+16 FTEE)	$+0.6
● A-76 Contracting of Cemetery Operations/ Employment Reductions (−73 FTEE)	−0.3
● Five Percent Pay Reduction	−1.1
● Supplies and Equipment	+0.9

General Administration

(dollars in millions)



Average Employment Down 154: (4,780 to 4,626)

Major Funding Changes:

● Productivity Improvements & Efficiencies (−58 FTEE)	$ − 1.7
● Closing of St. Paul & Los Angeles DPC's and Romney, W.Va Communications Facility (−113 FTEE)	+ 0.5
● Transfer of Specialized Recruitment Unit for Medical Personnel (+17 FTEE)	+ 0.6
● Five Percent Pay Reduction	− 5.4
● Office Automation	+ 2.0
● ADP Equipment Rental & Miscellaneous Adjustments	+ 2.8
● General Nonpayroll Costs	+ 0.5

STATEMENT OF
DONALD L. CUSTIS, M.D.
PRESENTED TO
THE HOUSE COMMITTEE ON VETERANS'AFFAIRS
CONCERNING THE
PROPOSED FISCAL YEAR 1986 VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY BUDGET
FEBRUARY 20, 1985

Good morning Mr. Chairman, I am Donald L. Custis, M.D., and I had the pleasure to serve as the Chief Medical Director of the Veterans Administration from January 1980 until May 1984. I appreciate this opportunity to comment on the proposed Fiscal Year 1986 Budget for the V.A.'s Department of Medicine and Surgery. As always, it is a pleasure for me to appear before the House Committee on Veterans' Affairs and address our mutually shared concerns for the health care of the nation's veterans.

The FY 86 budget for the V.A. Department of Medicine and Surgery in gross figures gives the misleading impression that resources are being frozen at essentially current services level. However, a line item study of that budget together with references to multiple statements printed in various OMB budget guidance papers, gives cause for concern. Disturbing also is the use of inaccurate data, misleading statements, and even aspersions upon the V.A. health care system.

To name a few examples:

Excerpt: "The VA projects that (due to the impact of the aging veteran) maintenances of the status quo policy will result in annual medical care and construction requirements as high as $37 billion by the year 2000."

Fact: The VA in its publication "Caring for the Aging Veteran" estimated this cost at something between $18 and $22 billion, the net increase in which would be largely offset by expected reduction in compensation and pension funding.

Excerpt: "89 percent of all veterans have private health insurance coverage."

Fact: Various surveys have shown this figure to be not less than 36 percent and not more than 51 percent.

Excerpt: "Virtually all of these over 65 veterans, like the rest of the elderly population, will be fully covered by medicare."

Fact: They are not now and will be even less so in the future.

Excerpt: "Despite repeated assertions, elimination of exclusionary (insurance policy) clauses will not lead to abandonment by veterans of the VA system -- known as "mainstreaming."

Fact: Entitlement for third party reimbursement has absolutely nothing to do with "mainstreaming".

Excerpt: "The 1986 resources will support the 'aging vet.'"

Stated elsewhere: "Funding caps provide no guarantee that resources necessary to provide care to disabled and poor veterans will be available".

Excerpt: "Despite the fact that VA draws heavily on low-cost intern and resident services, the average patient treated by the VA costs the taxpayer more than the comparable Medicare patient treated in the private sector."

Facts: This statement is categorically not true. (Parenthetically the internship was done away with several years ago. The FY 86 budget cut funding for resident physicians by $14,340,000.)

Excerpt: "In 1983, only 10.8 percent of VA health care was delivered to the service-connected (SC) population."

Fact: At any given time approximately one third of all in-patients and one half of all out-patients are service connected.

Excerpt: "Outlays for medical care and facility construction have grown at 12 percent average annual rate producing a 5 fold increase since 1970."

Fact: What is not said is that in constant, inflation corrected, dollars, there was straight line budgeting between 1975 and 1985. During that decade all growth was due to increased productivity and cost containment. To quote the VA Administrator "The VA continues to lag behind annual inflation increases significantly. This rate of growth has not resulted in deserved recognition of our Nation's veterans."

The proposed FY 86 budget shows, in several instances, disdain for Congressional mandates and prerogatives. Most blatant perhaps is the recent arbitrary cut in 1985 medical care employment of 2,092 FTE from the 193,941 FTE which Congress ordered. Carrying reduced this 1985 personnel level into FY 86, an additional denial was made of 2,068 FTE to staff eleven new nursing homes and other clinical facility activations. The VA identified a need of 2,594 FTE for these activations, but the request was cut by over 500 and direction given to absorb the balance. And then a further decrement of 1,916 FTE was exacted for pay reduction and an expectation of increased productivity. In actuality there will be 6,076 employees below the number needed to make it a "current services" budget, but figures are so juggled as to claim a new increase of 199 FTE over the 1985 Medical Care employment. In spite of this, increased workloads are set for both in-patient and out-patient care.

Similarly ignored is the Congressional mandated bed level of 90,000 - to include hospital and nursing home beds only. Budget documents now include domiciliary beds to this tabulation. In FY 86 2,761 hospital beds are to be closed and 1,847 additional nursing home beds opened by conversion (204) or new construction (1,643). The combined hospital/nursing home bed level falls from 89,570 to 88,656.

A two percent increment of $181 million is allowed for inflation, but that will be partially nullified by an inability to achieve all of the savings from management reduction programs for which $271 million was decremented -- programs such as A76 and 3rd party reimbursement.

There are two such management initiations introduced in this budget and incorrectly labeled cost saving programs, namely, a means test to look behind the poverty oath, and the legislative proposal for third party reimbursement. I personally have strong reservations about each and define those concerns in an article I am submitting as an attachment to this statement. Briefly, I believe the unmet patient demand on the VA system is so great that any means test will not in itself accomplish any workload reduction. A means test could be a valuable management tool however, if it were designed to be flexible, equitable and practical. Third party reimbursement is also not really a cost savings provision but rather a way to shift costs from the taxpayer to the insurance premium payer.

Cuts in MAMOE funding are much more critical than they appear. Employment reduction in DM&S Central Office may be twice the figure given of a 78 FTE, because of lack of sufficient personnel services dollars.

In the above referenced attachment comment is made regarding FY 86 restraints on construction and the impacts of other cuts. I would, however, like to observe that the OMB policy of exacting $1.10 in FTE resources for every one dollar expended on ADP procurement flies in the face of private sector experience. It is nevertheless an effective way of forestalling innovation and productivity gains.

My chief concern, however, has to do with what the projected outyear numbers portend for the future integrity of the VA health care system. Policy is clearly being made through the budget process and OMB's announced intent is to eliminate another 8,000 health care employees by 1990, provide no resource enhancement in anticipation of the impact of the aging veteran and only permit new construction based on "service-connected demographic justification".

Mr. Chairman I do appreciate the economic situation and the difficult job facing the Congress of dealing with the budget deficit. If, however, the VA health care system is to be squeezed there are ways to do so without threatening its integrity or compromising its quality. I refer to vertical cuts instead of continued horizontal leveling. There are hospitals that could be closed and others which should be entirely converted to nursing homes, There are cost efficient alternative programs to institutionalize care which should be permitted to expand.

If we have really come to the issue of its survival certainly this system is a national resource worth saving. There are multiple arbitrary line item caps in this FY 86 budget which are very destructive. The Department of Medicine and Surgery is in the hands of extremely talented people who should be given the management flexibility for the most judicious use of restrained resources.

THE CHALLENGE TO THE V.A. HEALTH CARE SYSTEM

PORTENTS OF THE FY'86 MEDICAL CARE BUDGET

Donald L. Custis, M.D.

A new dimension was applied this year to the FY'86 Federal Budget process. Under a strategy called "front loading", recommendations of the Office of Management and Budget for drastic cuts in domestic programs were presented to the President and leaks provided to the press prior to the usual return of budget proposals to the respective Federal Agencies for their final review and rebuttal. Especially noted was the President's personal involvement in line-item decision making, thus altering his traditional role as a detached final arbiter between agency heads and OMB. The technique was undoubtedly designed to arouse public interest at the earliest possible stage of budget development. No response was more vocal than the protests from those who truly understand the devastating impact of further cuts in Federal health care programs. Their concern, however, is currently without popular support. The public is preoccupied with rising health care costs, but generally lacks understanding of the causes. Unfortunately, the emphasis in public discussion of this extremely complex issue has shifted totally from the recognition that as a nation we have been successful in building the world's best health care system, which provides access to quality health care to all sectors of our population, to one that focuses exclusively on the cost factor. More ominous still is the tendency to ignore the fact that such medical care elements as human concern, compassion, and social responsibility simply do not translate into economic values.

The media, speculating on the Administration's intent, identified likely cuts in excess of what finally surfaced in the President's 1986 budget. Perhaps the press abetted a ploy of threatening the loss of a whole loaf in order to cut it in half. Given Congress' budget prerogatives, it will be months before final decisions are known. Even then the debate regarding the restructuring of the nation's health care programs will continue. Even previous discarded policy issues may be expected to resurface in subsequent budget cycles. The Administration has already proposed additional cuts for FY'87 and FY'88. FY'86 budget cuts affecting the private sector are also of significance to veterans because of the impact upon the VA health care system. During the past few years Congress has reduced projected Medicare/Medicaid expenditures by some 18 billion dollars. The President has proposed additional cuts from Medicare and Medicaid of $5.9 billion in FY'86 and $27.1 billion by FY'88. Included are reductions in Medicare reimbursement for capital expenditures; a fifty percent reduction in Medicare indirect subsidy for medical residency education and severe cuts in federal support for medical education loans and scholarships.

The fate and future of the V.A. and the private sector medical systems are inextricably linked. One third of all veterans over the age of sixty-five are said to be medically indigent, which may explain why the V.A. medical system is proving to be a demonstrable safety net for veterans who can no longer afford the increased co-payments of Medicare. In 1983 some 800,000 of the three million veterans over age sixty-five came to the V.A. for one form of care or another. That represents over twenty-five percent of all veterans in that age group. And one half of them had never previously made use of the V.A. health care system.

FY'86 budget decrements for the V.A. Department of Medicine and Surgery are, in many ways, reflective of options under continued study by the White House Office of Policy and Planning. These options have been identified in the recent Congressional Budget Office report on "V.A. Health: Planning for Future Years", the notoriously flawed Grace Commission Report, and by the Office of Management and Budget itself.

It is unlikely that the V.A. health care system could be dismantled by fiat, but there is clear and present danger that full implementation of certain of these options would be tantamount to its destruction. Unfortunately, the purpose, the nature and the value of the system as a national resource is little known and even less understood by the public. Only with such understanding can the impact of certain policy proposals targeting veterans medical care be measured.

The V.A. Department of Medicine and Surgery is the nation's largest integrated comprehensive system. It is the only system providing a full continuum of health care to veterans made eligible for care on the basis of laws passed by Congress and signed by the President. From its research laboratories have come tremendous contributions to medical knowledge. The V.A. is also the nation's single largest health manpower production resource and, as a key element in national security, the principal on-line contingency backup to military medicine. It is a system clearly worth saving. It is, in fact, a model for the nation, a harbinger of things to come. Its integrated, comprehensive provision of service is a blue-print for the vertical and horizontal integration now underway in the private sector's effort to adjust to the competitive medical market.

Up front should be an appreciation that the V.A. has an exemplary record in cost containment. There has been no growth in terms of inflation corrected constant dollars in its annual medical care budget for the past ten years. During this time the annual inflation rate for the Medical Care Price Index averaged twelve percent while the yearly V.A. medical operating costs increased by seven percent. The FY'75 V.A. medical care budget figure was $3.7 billion and in FY'85 $3.6 billion-in constant 1975 dollars. During this decade of straight line budgeting there was, however, a marked increase in productivity and economy. The average length of patient stay was reduced by one-third and the total annual patient work load increased by thirty percent. Annual out patient visits increased by two million. An additional 3,723 nursing home beds and sixteen out patient clinics were added to the system and 136 new Veteran Centers provided readjustment counseling to over 300,000 Vietnam veterans. During the same period sixteen thousand V.A. hospital beds were closed.

A series of national-level policy issues and "choices" is aswirl around the V.A. health care system, some driven undoubtedly by budget prerogatives and agendas, but others by larger philosophies or even fear and greed. All are intertwined, as is the V.A. medical care with American medicine. Depicted here are the issues most critical for future vitality of the V.A. system. Further evolution and resolution of these issues will occur as the debate heats on future directions for V.A. health care delivery.

Issue number 1: Eliminate acute care services in the V.A. health care system.

None of the options under consideration for altering the modalities for veterans medical care would have more devastating consequences than the recommendation to discontinue, entirely, acute care services within the V.A. system. In this option, as described by the Congressional Budget Office, "the V.A. would continue to assist poor veterans and those with service-connected disabilities in obtaining medical care for acute illness in private hospitals on a contract, a fee-for-service basis or through a reimbursement mechanism as yet undefined.

Without the case mix represented in current V.A. patients, the quality and continuity of care within the V.A. health care system would rapidly decline, and the system, thus limited to long-term chronic care, would revert to a chain of "Old Soldiers Homes". V.A. hospitals would have little value as a teaching base for health professionals or the pursuit of clinical research. Medical school affiliations would be cancelled and the major incentive lost for V.A. recruitment and retention of high quality medical staffs.

The ability of the V.A. health care system to serve as a backup to military medicine would also be eliminated.

Many veterans would lose medical care since much V.A. specialized care is not universally or readily available in communities. This is especially true for amputees and the functionally disabled with their continuing need for prosthetic and orthotic management. The V.A.'s provision of sustaining care for the spinal cord injured has no counterpart in the private sector.

Similarly, the professional insight and therapeutic management of the psychoneuroses of war are largely a V.A. accomplishment. The V.A. psychiatric case load simply could not be absorbed in community facilities. The existing state mental health systems are notably ill equipped to handle more patients. Too many psychiatric patients have already been discharged onto the streets of our cities without adequate support systems.

This option does not represent cost savings, it only shifts costs. In fact, the aggregate cost to the V.A. for service-connected veterans' acute care could materially increase were this option approved. The V.A.'s cost comparison studies indicate that acute care in the private sector is less economical than in the V.A. Additionally, the two-thirds of all service-connected veterans now using private hospitals could start billing the V.A. for reimbursement. The medically indigent non service-connected veterans would be a heavy extra load on the already stressed Medicare/Medicaid program with the safety net of the V.A. system no longer available to them.

Issue Number 2: Limiting V.A. health care eligibility to only the service disabled and veterans in receipt of pensions.

This option carries consequences not unlike those described above. Although the patient case mix in the V.A. medical facilities would not be so drastically changed, even the Congressional Budget Office concedes that it might make DM&S too small to be viable, particularly with regard to its academic affiliations.

This action would cut the V.A. patient census in half and necessitate the closing of dozens of V.A. hospitals. The capacity to backup the Department of Defense likewise would be materially reduced. It is the non service-connected veteran who accounts for the great bulk of indigence in the V.A. system patient census. When a mandated "means test" was last applied, a data analysis revealed that over 98% of the non service-connected patients were indeed in the poverty class. Under this option many of these veterans would be Medicaid candidates who would heavily impact the county and municipal charity bed resources.

Currently one-half of all V.A. health care system outpatients and two-thirds of all inpatients are veterans with non service-connected disabilities. They have, historically, been given entitlements to V.A. hospital care on a space, or resource, available basis and, for the past decade or more, access to ambulatory care for the purpose of avoiding hospitalization. The elimination of this case load would compromise the maintenance of the staff expertise for quality care of the service connected. Arbitrarily drawing the line on entitlement between service-connected veterans and non service-connected is morally untenable. While the V.A.'s primary charge is to care for those veterans whose disabilities were incurred during military service it has always strived not to abandon those whose subsequent disabilities have rendered them unable to care for themselves. This is, at the least, social equity, applicable to veteran and non veteran alike, and exemplifies that what we as Americans believe is one source of our national strength; we care for those who cannot care for themselves.

Issue Number 3: Vouchering.

Vouchering has been under consideration for some time by certain health care economists as a modality for Medicare resource distribution and for what is euphemistically called "mainstreaming" of veterans' medical care. While a vouchering option could have varied designs and provisions, the model most often referenced for consideration in Medicare and by V.A. mainstreaming proponents is a voluntary capitation system wherein the enrollee would be given a set price voucher to use at his or her discretion to purchase health insurance or health care in the private sector. Although the call for mainstreaming of veterans' care has thus far gone unheeded, the threat remains because of its appeal in some segments of the private medical sector. While Medicare vouchering may be a feasible option, mainstreaming could spell disaster for the continued integrity of the V.A. medical system.

At the present time the Department of Medicine and Surgery spends ten percent of its medical care budget for purchase of private medical care and services, generally, in geographic areas where there is no V.A. medical facility presence. With open ended vouchering, however, it is likely that most acute care would be siphoned from the V.A. system with an end result identical to a mandated discontinuance of V.A. acute care capability as discussed previously. Space available V.A. medical care for the non-service disabled veteran presumably would disappear and it is problematic whether vouchering would be authorized for them. As noted in issue number one costs for service-connected care would increase since those service-connected veterans not currently using the V.A. system would likely take advantage of such universal subsidy.

Once there is established such an alternative as mainstreaming, the V.A. health care system, which has served the veteran and the nation so well, would be slowly undermined until its continued existence would be doubtful.

Issue Number 4: Restraints on construction and maintenance.

The proposed FY'86 budget not only would freeze V.A. medical care at the FY'85 level, but also reduce the construction budget by more than fifty percent of projected need, funding only certain projects with outlays already committed.

It had been previously determined that just to replace the system's antiquated hospitals and maintain its plant facilities at the current size would require a one billion dollar (in constant '85 dollars) construction budget for the next ten years. The proposed FY'87 and FY'88 figures continue to ignore that reality. Implication of intended future policy is also to be found in the FY'86 guidance that construction projects in the out year should be sized solely upon service-connected demographic need. This is consistent with the Administration's limitation of nursing home construction to two 120 bed facilities in FY'86, a reduction of 720 beds from the level requested. It also serves as an introduction to the following issues:

Issue Number 5: The impact of the aging veteran.

The Administration, through its FY'86 budget proposal, makes quite clear its imperviousness to any understanding of the medical needs of the aging American, let alone the aging veteran.

The coming impact of the aging veteran had been a responsibility which the Veterans Administration was taking very seriously. After more than a year of demographic analysis, discussion and review by outside consultants, it published in mid 1984 a comprehensive report "Caring for the Aging Veteran". The veracity of this report was further supported by a Lou Harris survey and contracted studies by Harvard University's Division of Health Policy Research and Education. A simultaneous report from the Congressional Budget Office concurred with the data obtained from the V.A.'s demographic survey.

The V.A. plan provided a detailed overview, based on projected need, of the opportunities presented by the aging of its constituents. Where as three million veterans today are over age 65, by the year 2000 that number will triple to nine million or 36 percent of all veterans. Because it is dealing with a population whose average age is increasing much faster than that of the general population, the V.A.'s accommodation to this impact could serve as a proving ground for private sector programs to follow.

To maintain current levels of care the nation's elderly will by the year 2000, occupy all of the today's empty hospital beds and require a fifty percent increase in present nursing home facilities. In more dramatic terms tomorrow's elderly will require the opening of one hundred nursing home beds every day for the next fifteen years. Today the V.A. alone supports an average census of twenty five thousand veterans in nursing homes, sixty percent of whom are in community nursing homes. This need will double by 1995.

The main emphasis in expanding V.A. geriatric capability, however, was to be placed on non-institutional care programs such as outreach satellite clinics, adult day care centers and rehabilitation units, hospital based home care and hospices. The V.A. had intended to seek legislation in this area for increased sharing and coordination with the private sector. The goal was to exert maximum effort to integrate V.A. programs for the elderly with similar programs in the community at large.

In spite of these well documented requirements no program enhancement resources appear in the proposed coming year budget or in its out year projections. In contrast, OMB budget guidance contains the words "shrink the V.A. system size gradually." Blocking the development of geriatric program alternatives to institutionalized care will have a stultifying effect on the V.A.s system, and will itself add to overall costs and, in turn, drastically retard the nation's preparedness to meet the medical and socioeconomic needs of its aging citizens.

Issue Number 6: Eliminate V.A. budget support of health professional education.

The White House Working Group on Health Policy and Economics has directed the Veterans Administration to identify the dollar savings by severing all medical training from patient care resources. This concept has already been applied incrementally by OMB in its proposed FY'86 Medicare budget, by cutting in half the dollars supporting post graduate education of physicians. The VA's education and training fund is also to be cut 10% below current services.

This is a concept in defiance of the basic premise that medical education, medical research and patient care are absolutely integral to one another. Unlike most professions, the teaching of the science and art of medicine can not be confined to lecture halls. The making of a physician occurs at the patient's bedside. In the process, medical care is simultaneously delivered and is generally conceded to be the most economical and the highest quality of care. A study of this issue is currently being pursued under contract by the Department of Health and Human Services.

In the post World War II years, the designers of the modern V.A. health care system built its foundation on an extensive affiliation with medical schools. Today, 104 medical schools are affiliated with 130 V.A. hospitals. One-third of all graduate medical students in the U.S. receive some part of their speciality training in V.A. hospitals. Considering all health care disciplines there are, at any given time, 100,000 students -- physicians, nurses, psychologists, lab technicians, etc. -- in training within the V.A. network. The great bulk of this health manpower output accrues to the private sector.

Medical residents alone make up almost fifty percent of the full time equivalents devoted to V.A. physician employment. The average medical resident stipend is one-third that of a V.A. staff physician. The total expenditure for all education and training is four percent of the total Department of Medicine and Surgery medical care budget. If affiliations were eliminated this year, it would take approximately 180 million additional dollars to replace the V.A. resident physician staff with full time medical staff. In fact, lacking the ability to pay high salaries, locate physicians in non-urban areas, deny opportunity for teaching and research, or offer other incentives, it would be impossible for the V.A., without medical school assistance, to recruit many of the specialists it requires for patient care. Conversely the schools would be hard pressed to support many of their faculty.

That the nation's medical schools need V.A. affiliations is an understatement of significant order. Owen Wangensteen, nationally renowned surgeon and medical educator, once said that the three greatest contributions to the advancement of American medicine during his career were the Flexnor report (resulting in medical school reformation in 1913), the creation of the National Institutes of Health and the V.A./medical school affiliation program.

Coupled with the loss of affiliations and the teaching mission would come the abandonment of DM&S research. Here again, the public is generally uninformed of V.A. research contributions to medical knowledge. A short list of those achievements include: the chemotherapy of tuberculosis and modern treatment of hypertension; the first cardiac pacemaker and the invention of the nuclear powered pacemaker; the discovery of cancer causing viruses; the robotic limb; the smart wheelchair; the self-suspending prosthetic suction socket; the invention of kidney dialysis; the first kidney transplant; the first liver transplant; the technique of radioimmunoassay; the basic concept of computerized axial tomography and the list goes on.

Budget analysts, in their designs on V.A. medical education and research, need be reminded of the adage concerning the baby and its bath water.

Issue Number 7: Cost reduction myths.

Two issues under the heading of cost savings surfaced in the FY'86 presidential budget process, also raise concern. While presenting no threat to the continued integrity of the V.A. health care system these issues, as cost saving tools, are, at best, canards.

One is a means test recently intended to be implemented early this year and purported to save 400 million dollars by FY'88. A workable means test has, historically, been difficult to design. The V.A.'s latest version has recently been returned by OMB for further study and design.

A means test for use in the V.A. could be a valuable management tool were it made to be flexible, equitable and appropriately applied. Its use has already been approved by Congress in PL 96-330. But that legislation did not mandate a universally applied means test. It merely authorized the V.A. Administrator to design and make use of a means test according to his discretion in order to check, when indicated, an the validity of a veteran patient's use of the poverty oath. The report accompanying this legislation from the House Committee an Veterans' Affairs also specified: "The determination of providing care to this category of veterans is necessarily a subjective one, entailing consideration of not only the ability privately to pay for the expenses of an illness or injury, but also a judgement of whether or not the disability can be expected to require such a period of lengthy hospitalization as can be reasonably expected to exhaust the veteran's private resources."

The means test which was almost implemented was discriminatory and flawed in several respects.

It was to have been applied prospectively, at the point of entry into the system, to all non service-connected veterans except ex-prisioners of war, those over the age of sixty-five and those in receipt of pension. A preliminary and cursory medical evaluation would have provided the basis for determining the cost of private care and the veteran's ability to pay for the current episode of illness.

In contrast to what had been intended, a rational and equitable means test could be very useful were it to include the following features:

It should not be prospectively applied at the time of admission, based upon preliminary medical evaluation, but only after admission and the completion of a definitive diagnostic work up. Treatment costs should also consider the probabilities of protracted illness, and the ongoing or recurrent need for medical care, in making "ability to pay" determinations for these veterans.

It should be equitable as to age and geographic location. Special entitlement for the over 65 non service connected patient who is able to pay for private care may have once served a purpose, but under today's Medicare circumstances it has become discriminatory. If the V.A. health care system is to continue to meet the medical demands of service-connected veterans and non service-connected veterans truly unable to defray expenses, any means test must be applied equitably to every one in the latter group. Similarly, it must contain the flexibility to accommodate geographic differentials.

Living costs vary dramatically from region to region within the nation. A veteran residing in New York or San Francisco may have significantly less disposable income, even with a higher gross household income, than a veteran living in a rural area.

Finally there should be incorporated in any means test program an appellate process. Regulations covering application for all other V.A. benefits provide such recourse.

Means test screening of applicants for V.A. medical care should not be promoted as a cost saving tool, for no real savings can be predicted due to the inherent administrative costs and speculative estimates of reduced veteran demand. Since the V.A. is now turning away twenty thousand veterans every month for lack of adequate budget resources, for every applicant denied care through means testing there will be several more waiting to take his or her place.

Equally illusory is the cost saving repeatedly expected from a proposed expansion of third party reimbursement authority. The V.A. already has the authority to collect reimbursement for certain non service-disabled veteran patients who are eligible for worker's compensation or from insurance companies whose policies do not forbid such payments. Such third party reimbursement could justifiably be extended to recoup retrospectively the cost of VA furnished diagnostic procedures once a non service-connected veteran was found able to bear the cost of referral to the private medical sector.

Beyond that, however, the espousal of universal third party reimbursement to the V.A. has no rational conceptual basis except to shift the cost of medical care within the VA system from the taxpayer to the at-large insurance premium payer. All health insurance holders, including those under Medicare, will assume that extra burden. The revision of health insurance contracts will be slow and difficult and will entail added administrative costs both to insurance companies and to the V.A.

Parenthetically, data from a V.A. survey in cooperation with the Bureau of the Census showed that 64 percent of patients receiving care in VA hospitals have no health insurance at all, 16 percent qualify for Medicare and only 15 percent have some private health insurance. In contrast 90 percent of all of society have some form and degree of health insurance.

Returning to the commonality of concern regarding the program impacts of budget cuts on the private, public and veteran health care systems, one pervasive underlying frustration is dominant. This Administration, as well as Congress who gave us DRGs, PROs, PPOs and the other ingredients of the competitive medical model, have shown little interest in tackling the problem of uncompensated care, poor quality of care or the total denial of care to the indigent, the aged and the disabled. Jack Owen, Senior Vice President of the American Hospital Association, has aptly stated: "Someone has got to pay for those who can't. There is no such thing as free medical care. If we can't find a way to care for our country's poor, our health care system is a failure." The ethical underpinnings of a civilized society's social conscience and responsibility deserve more than rhetorical allusions, especially at this time when the era of the longevity revolution is upon us.

The size and demands of the nation's aging phenomenon are not easily grasped, but the implications as detailed in the medical and socioeconomic literature surely deserve more than total neglect in the design of health care policy. How long will society tolerate the narrow-minded opinion that the coming impact of an aged citizenry is but a further aggravation in medical economics which can only be solved by the rationing of medical care?

Oliver Wendell Holmes once said that the strength and security of a nation can be measured by its domestic humanitarianism. Eli Ginzberg, writing in a recent issue of the New England Journal of Medicine, voiced the deepening concern about the growing conflict between medical ethics and the monetization of medical care.

If the current neglect of ethical and humanitarian imperatives in health care legislation is to be reversed, corrective intervention will require more circumspect political leadership backed by professional and informed societal demand. Veterans can and must be a potent segment of such a consortium.

This is no time to "shrink the V.A. health care system"!

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS

MR. CHAIRMAN, I JOIN YOU IN WELCOMING V.A. ADMINISTRATOR HARRY WALTERS AND OUR OTHER DISTINGUISHED GUESTS HERE TODAY. MR. WALTERS, MAY I TAKE THIS OPPORTUNITY TO CONGRATULATE YOU ON THE VERY FINE JOB YOU DO AS ADMINISTRATOR OF THE VETERANS ADMINISTRATION AND ITS MANY IMPORTANT PROGRAMS. IN MY OPINION, THE VETERANS OF THIS COUNTRY ARE IN EXCELLENT HANDS AND I KNOW THEY APPRECIATE YOUR STRONG COMMITMENT TO THEM, AS DO I.

I CERTAINLY LOOK FORWARD TO YOUR TESTIMONY THIS MORNING AND I KNOW YOUR INSIGHTS WILL ME MOST HELPFUL TO US AS WE CONSIDER THE VARIOUS BUDGET PROPOSALS OFFERED BY THE ADMINISTRATION. FORMULATING A BUDGET IS NEVER EASY, BUT THE VERY PRESSING NEED TO REDUCE THE FEDERAL DEFICIT ONLY MAKES OUR TASK THAT MUCH MORE DIFFICULT.

LET ME ASSURE YOU THAT I AM FIRMLY COMMITTED TO REDUCING OUR SWOLLEN FEDERAL BUDGET. HOWEVER, I BELIEVE WE MUST BE PARTICULARLY CAUTIOUS IN MAKING ANY ADJUSTMENTS IN VETERANS' BENEFITS AND SERVICES BECAUSE CARING FOR THOSE WHO HAVE BORNE THE BATTLE IS AND SHOULD CONTINUE TO BE ONE OF THE NATION'S VERY TOP PRIORITIES.

FOR OUR PURPOSES, THEN, ACHIEVING BUDGET SAVINGS CANNOT IN AND OF ITSELF BE OUR ONLY OBJECTIVE. THE QUESTION WE MUST ASK IS WHETHER THESE CHANGES ARE IN KEEPING WITH OUR OBLIGATIONS TO THE VETERANS OF THIS COUNTRY. IF THE ANSWER TO THAT QUESTION IS NO, THEN NO AMOUNT OF SAVINGS CAN JUSTIFY SUCH CHANGES. IF WE CAN HONESTLY ANSWER THAT QUESTION IN THE AFFIRMATIVE AND ACHIEVE SOME LEGITIMATE SAVINGS, THEN WE, INDEED, HAVE EARNED OUR KEEP.

THANK YOU MR. CHAIRMAN.

STATEMENT OF
CHAD COLLEY
NATIONAL COMMANDER
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
OF THE
U.S. HOUSE OF REPRESENTATIVES
February 21, 1985

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 920,000 members of the Disabled American Veterans, I am pleased to appear here today to discuss the budget request of the Veterans Administration for Fiscal Year 1986.

Let me begin by thanking you, Mr. Chairman, and the members of the Committee for soliciting our views on the Fiscal Year 1986 VA budget request prior to submitting your recommendations to the House Budget Committee.

As you know, Mr. Chairman, on behalf of the Veterans Administration, the President is requesting $27.1 billion in budget authority to administer the various programs and services for millions of the nation's veterans and their families in Fiscal Year 1986.

In budget authority, the VA request is approximately $123 million below the Fiscal Year 1985 level, primarily due to so-called projected savings that include:

* a 5% reduction in pay for federal employees;

* a decrease in funding for grants to states for construction of extended care facilities;

* implementation of third party reimbursement from private medical insurance policies;

* 1% across-the-board staffing reduction mandated by OMB;

* substantial reduction in construction funds;

* an increase from 1% to 5% in the user fee charged on VA guaranteed home loans.

Overall, Mr. Chairman, these projected savings, coupled with other budget proposals and non-budgetary actions by the Administration, set forth a road map for further decline in the VA's ability to provide continued quality health care and timely claims services to America's veterans.

MEDICAL CARE

The Fiscal Year 1986 budget request calls for an overall funding increase in the VA's medical care account of $235 million--an upward adjustment of approximately 2.6%--over the Fiscal Year 1985 level.

According to budget documents, this increase will provide 199 additional health care employees; treat 112,000 more veterans on an outpatient basis and 3,211 inpatients; and permit 204 hospital to nursing home bed conversions.

While these documents may indicate an increase in funding for the VA medical care account, upon closer examination it becomes clearly evident that for the current fiscal year and Fiscal Year 1986 VA bed levels and employees will, in fact, decline below that which has been mandated by law or previously authorized by the Congress.

Mr. Chairman, OMB and the VA have circumvented the law. In Fiscal Year 1985 VA will operate with 600 fewer beds than that which is required by Section 5010(a)(1) of Title 38, U.S. Code and in Fiscal Year 1986 bed levels will drop 900 below statutory requirements.

The HUD and Independent Agencies Appropriations, Fiscal Year 1985--Public Law 98-371--provided support specifically intended for 193,941 full time equivalent VA health care employees and the Comptroller General of the United States has confirmed that OMB has provided the funds and personnel ceiling appropriated by the Act.

Yet the VA says, "the agency now projects that the budgeted work loads can be achieved with an employment level of 191,849." At the same time, however, their own statistics reveal they are turning away more than a quarter of a million eligible veterans who are seeking VA health care services each year.

We must question, Mr. Chairman, why the VA or OMB has not informed the Congress that funding was insufficient to operate beds and provide employees at levels authorized or required by law? Or does OMB and VA have another reason for their failure to accurately and promptly inform the Congress of any shortfall in funding? Certainly, OMB has made it perfectly clear that they would like "to shrink the size of the system"--but shrink it to what, we ask?

As you know, Mr. Chairman, the VA health care system has been on the decline for a number of years due to negative (deflated) funding growth of the system. The proposed Fiscal Year 1986 medical care budget is no different than those of the past ten years. For example, last year's budget request for medical care fell 3.5% below the cost of health care in the private medical community and this year's request is again 3.5% below that which was experienced in the private sector during the same period.

Straight-line funding (in terms of real growth) coupled with such proposals as 5% pay reductions; across-the-board staffing reductions; cancelling nurses' scholarships under the Health Professional Scholarship Program; collecting reimbursements from private health insurers of nonservice-connected veterans receiving VA care; repealing the provision of Title 38, U.S. Code that gives veterans age 65 and over eligibility to VA hospital care; and establishing a means test for nonservice-connected veterans seeking VA care are further indications of OMB's real effort--destroy the VA health care system.

For example, collecting reimbursements from the private health insurers of nonservice-connected veterans receiving VA health care services is a rehash of an old idea that has time and again been rejected by the Congress.

Today, OMB estimates VA can collect $65 million from these private health insurers, while four years ago they said they could collect over $300 million. VA officials have publicly stated that they nor OMB have any sound basis for making such an estimate for this proposal.

Given the fact that most private health insurance policies provide exclusionary clauses prohibiting third party payments to the government, as well as the fact the vast majority of nonservice-connected veterans seeking health care from the VA have no private health insurance coverage, makes these collection estimates highly speculative. Then, if you include the added administrative expenses of collecting these payments, you end up with a proposal that could cost, rather than save, the government money.

Additionally, they propose to accomplish a "comprehensive reform of VA medical care eligibility" by (1) repealing Section 610(a) of Title 38, U.S. Code--providing eligibility for hospital or nursing home care to any veteran for a nonservice-connected disability if the veteran is 65 years of age or older--and (2) establishing a means test for certain categories of veterans without service-connected disabilities and without regard for age.

It is interesting to note that the Administration is only now proposing a means test that they were directed by the Congress to accomplish some four years ago.

Quite frankly, Mr. Chairman, the VA could develop a fair and equitable means test and the Congress could repeal Section 610(a) of Title 38, U.S. Code. The end result would be that nonservice-connected veterans with private health insurance would not be admitted to VA medical centers--thus, there would exist little, if any, need for third party reimbursement legislation.

Even if all this is accomplished, we believe that there will be a veteran to fill every bed vacated by those displaced by the proposed legislation.

One final point, Mr. Chairman, coinciding with the recent release of the VA's proposed Fiscal Year 1986 request, the DAV learned that OMB has directed the VA to accelerate plans to contract out positions within the VA health care system to the private sector.

As we understand it, OMB is seeking to eliminate some 30,000 jobs within the health care system over the next five years. Positions that are being scrutinized for possible contracting out include areas such as dietetic services, fire protection, plant maintenance and senatekeeping.

As you know, Mr. Chairman, this Committee and your counterpart in the Senate has, by law, prohibited the VA from contracting out any positions that directly relate to patient care. In our view, many of the jobs under consideration are, in fact, directly related to patient care and, as such, should be exempted from any contracting out review.

This is just another avenue being used by OMB to thwart the will of Congress and erode the VA health care system. We believe the funding associated with A-76 studies contained in the Fiscal Year 1986 budget could be put to better use--that is, providing care to veterans.

Mr. Chairman, we encourage you and the members of the Committee to carefully scrutinize the Fiscal Year 1986 funding levels proposed for the VA medical care account. We believe such scrutiny will lead you to recommend to the House Budget Committee realistic levels of funding that will acknowledge the growing demand that has been and will continue to be placed upon the VA's medical care system. And, should the Congress not impose the 5% pay reduction for federal employees, as proposed by the President, we respectfully request the VA health care system be exempted from absorbing the funds associated with the proposed legislation.

CONSTRUCTION

The VA's Fiscal Year 1986 construction request is $156.8 million below the Fiscal Year 1985 level. However, the VA proposes to reprogram $160 million in prior budget authority from the major working reserve to bring the program level to $771.6 million.

Mr. Chairman, while we support full funding of the VA's request for construction programs, we are nevertheless concerned, as I mentioned earlier, over the VA's effort to meet the pressing demands on the health care system.

As you know, greater numbers of elderly veterans are seeking nursing home care from the VA, yet, of this construction budget proposal less than 4% is requested for nursing home care bed construction. We have noted and support the VA's proposal to convert 204 hospital to nursing home care beds, as well as their efforts to replace and modernize its older facilities. However, we trust an appropriate balance will be maintained to meet the acute and intermediate health care needs of our aging veteran population.

Finally, the VA's Fiscal Year 1986 request contains a $12.5 million decrease (under the Fiscal Year 1985 level) in grants for construction of state extended care facilities. The VA's request of $22 million will provide for an additional 450 nursing home care beds and 126 convertible domiciliary/nursing home beds.

As you know, Mr. Chairman, this program has been a tremendous success in terms of encouraging states to actively participate in the nation's commitment to providing quality health care to her eligible veterans. In our view, it is shortsighted to cut funds in a program that ultimately makes savings to the government in terms of both construction and health care costs.

DEPARTMENT OF VETERANS BENEFITS

The Department of Veterans Benefits' Fiscal Year 1986 budget request is down by more than $4 million and 624 employees, compared to Fiscal Year 1985 levels.

According to budget documents, the 624 average employment reduction in DVB personnel is attributed to consolidation of certain regional office activities, declining work loads and management actions to reduce overhead and increase productivity.

As you know, Mr. Chairman, in 1981, this Administration first suggested the idea of consolidating all regional office activities into a number of super regional offices throughout the United States. For many good reasons that proposal was soundly rejected by the Congress.

Now, in 1985, this Administration again comes forth with a similar proposal to consolidate only adjudication of compensation, pension and education claims (including Rating Boards), loan processing, finance, administrative and personnel functions into three regional centers. This proposal would leave veterans' assistance, compliance survey, vocational rehabilitation and counseling, loan servicing, property management, and construction and valuation activities at each existing regional office, thus, relegating these facilities to nothing less than contact offices that provide general information, counseling and forward claim inquiries to the three regional centers.

Quite frankly, Mr. Chairman, we view this proposal, as we did in 1981, as bureaucracy at its absolute worst.

Since 1980, nearly 4,000 employees have been slashed from the Department of Veterans Benefits and, today, each regional office is barely staffed at minimal levels to handle the work load and demand for services from veterans and their dependents.

Consolidation of these already understaffed functions will not only worsen the delays veterans currently experience with respect to claims processing, but deprive them of direct access to the system. For example, no longer would veterans and their dependents have the opportunity for a timely, face-to-face hearing (within a reasonable proximity of their home) with a VA Rating Board and their appointed representative.

And, quite frankly, the proposal makes absolutely no economic sense whatsoever. Millions of dollars would be required to relocate employees, obtain office equipment, acquire huge amounts of office space and train new employees (to replace those who did not relocate).

Mr. Chairman, the DAV strongly urges you and the members of the Committee to soundly reject this poorly conceived plan, redirect the $25.1 million the Administration is requesting to implement the plan and restore the 624 DVB employees desperately needed by the regional offices to improve services to veterans and their dependents.

PROPOSED LEGISLATION

The Administration's Fiscal Year 1986 budget request proposes legislation that would provide for (1) an increase of 4.1% in the rates of disability compensation and Dependency and Indemnity Compensation (DIC) effective December 1, 1985; (2) increase from 1% to 5% the loan origination fee on all guaranteed and vendee loans; (3) allow for borrower/lender negotiated rates on guaranteed and vendee loans (mortgages), and terminate the Administrator's authority to set interest rates; (4) repeal transfer authority from direct loan revolving fund to the loan guaranty revolving fund; (5) repeal the authority that permits the VA to make education loans; and (6) to effect reimbursement from third party insurance carriers for the cost of care and treatment of nonservice-connected veterans (to which I addressed our concerns earlier).

The DAV is pleased with the Administration's proposed cost of living adjustment in the rates of disability compensation and DIC benefits--in recognition of the special consideration service-connected disabled veterans and their survivors should be given.

Accordingly, Mr. Chairman, the DAV supports the enactment of legislation that would provide disability compensation and DIC recipients with a cost of living adjustment in line with the rise in the Consumer Price Index effective December 1, 1985.

As noted, the Administration has proposed several legislative changes to the current VA Home Loan Guaranty Program. Of particular concern to most veterans are the proposals that would increase the user's fee from 1% to 5% and remove the Administrator's authority to set the interest rates for such home loans.

Quite frankly, these two legislative initiatives appear to be sufficient to effectively destroy the VA Home Loan Guaranty Program. Yet, the Administration is projecting 250,000 loans will be generated next year by this program.

Mr. Chairman, why would a quarter of a million veterans fork over $3,000 to $5,000 just for the privilege of using this program, while not one nickel will reduce the principal of their mortgage? How much would they pay for this privilege over 25-30 years?

Coupling this exorbitant user's fee with the removal of the interest rate ceiling nearly eliminates any benefit to veterans. We believe the Committee should carefully evaluate the adverse impact these proposals will have upon the Vietnam veterans who are the primary beneficiaries of the program today and, should they be rejected, we respectfully request that the Department of Veterans Benefits be exempted from absorbing the funds associated with the proposed legislation.

VETERANS' EMPLOYMENT PROGRAMS

Mr. Chairman, we have also reviewed the proposed budget for veterans' employment and training programs administered through the office of the Assistant Secretary for Veterans' Employment and Training.

The Administration has proposed $12.6 million, providing 282 staff positions for the office of the Assistant Secretary for Veterans' Employment and Training. While this represents a slight decrease in the total dollar amount, it still proposes to fund the same 282 positions it did for Fiscal Year 1985.

As you know, the office of the Assistant Secretary for Veterans' Employment and Training now has the responsibility for distributing the funding for the Disabled Veterans Outreach Program (DVOP) and the Local Veterans Employment Representative (LVER) program. In this regard, the 1986 budget proposes $60,845,000 and $50,641,000 for the DVOP and LVER programs, respectively. While the overall dollar amounts are slightly increased, the number of positions for DVOP and LVERs decreases from the Fiscal Year 1985 level.

Mr. Chairman, we must express our concern for the continued employment services provided to veterans by DVOP and LVER personnel.

As you know, the state employment security agencies during the last four years have lost approximately 33% of their staff. While DVOP personnel are not counted as part of that staff, the LVER personnel are included. Therefore, with the overall decline in personnel system-wide, we fear reduced services to eligible veterans seeking assistance from DVOP and LVER personnel.

CONCLUSION

In closing, Mr. Chairman, in addition to the views we have already set forth with respect to the VA's proposed Fiscal Year 1986 budget request, I want to emphasize that the main reason this budget request is below the Fiscal Year 1985 level--and still provides for a cost of living adjustment in compensation, DIC and pension benefits, as well as adding funding to the VA health care program--is due to unrealistic legislative proposals crafted by the Administration.

Therefore, we urge the Committee to favorably recommend to the House Budget Committee restoration of the levels of funding deleted by these unrealistic proposals, thereby providing the VA with funding that adequately addresses the needs of those programs administered by the VA.

Again, I wish to thank you and the members of the Committee for allowing us this opportunity to express our views on this most important subject.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

FEB 15 1985

Mr. Gary Cole
Budget Officer
Veterans Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Gary:

Enclosed is a revision of our joint paper describing the broad guidelines of the comprehensive reform of medical care eligibility. Enclosed as well is a list of additional points of clarification that will be helpful as responses to questions that the Administrator may be asked during his testimony.

We believe these represent the agreements and understandings that we have reached in our February 13 meeting and subsequent conversations.

Sincerely,

Susan S. Jacobs
Chief, Veterans Affairs Branch
Labor, Veterans and Labor Division

Enclosures

VA ELIGIBILITY REFORM
ADDITIONAL POINTS OF CLARIFICATION

- World War I, Spanish American War, and Mexican border period veterans would be eligible for hospital, nursing home, and outpatient care.

- The legislative proposal would specify the eligibility level as double the pension income standard.

- Details of what types of out-of-pocket expenditures on medical care by the veteran, e.g., copayments, deductibles premiums, fees, will be part of the expected medical expense contribution and will be worked out by the VA, OMB, and the White House Health Policy Working Group.

- When both the veteran and third party payers are to be billed by VA, the veteran will not be asked to pay the private insurer's share of the charges and wait for reimbursement from the private plan. If the amount of reimbursement from the private plan is known, the veteran can be billed immediately, otherwise billing of the veterans may be delayed until collection from the insurance company is received.

- VA care is not intended to be a substitute for Medicare for veterans with Medicare coverage and incomes above double the maximum annual VA pension rate. These veterans would first seek care available to them through their Medicare coverage. However, after these veterans make out-of-pocket expenditures up to their expected medical expense contribution, they will be eligible for VA care. Veterans with Medicare eligibility and incomes below double the pension level will be admitted to VA whether or not they have first used their medicare benefits.

- The VA will not be the primary provider of care for veterans with incomes above double the pension income standard. In most circumstances these veterans would receive care, medical examinations, and diagnoses in non-VA facilities, and would enter the VA after having received care elsewhere. As a result, in most circumstances, veterans with this income level would not require an examination to determine whether or not they are eligible to enter the VA. The determination would be based on income and prior out-of-pocket medical expenses. The burden of proof rests with the veteran.

- In situations in which a veteran arrives at a VA medical center claiming to be in need of immediate attention, a preliminary admitting examination could be administered. If immediate care is not necessary to prevent loss of life and limb, the veteran would be billed for the examination if deemed ineligible.

VA MEDICAL CARE POLICY

Six key ingredients to comprehensive reform of VA medical care eligibility.

1) Repeal Section 610(a)(6) of Title 38

   - This section provides non-service-connected veterans age 65 and older with eligibility for VA hospital and nursing home care without regard to their "inability to defray" the expense of such care.

2) Continue existing eligibility within the limits of VA facilities based on medical determination of need:

   - Service-connected veterans for service-connected disabilities;
   - Service-connected veterans for non-service-connected conditions;
   - Veterans who were prisoners of war;
   - Veterans exposed to ionizing radiation during military service (Atomic veterans);
   - Vietnam War veterans exposed to certain herbicides during military service (Agent Orange veterans);
   - VA pensioners; and
   - World War I, Spanish American War, and Mexican Border Period veterans.

3) Clarify and define eligibility for other non-service-connected (NSC) veterans based on inability to defray necessary hospital and nursing home expenses.

   - Amend Title 38 Section 622 to add language identifying that if other NSC veterans are able to demonstrate, with verifiable evidence, that gross annual family incomes including assets (as defined in the Improved Pension program) are below double the maximum annual VA pension rate based on family size, such individuals are deemed to be unable to defray necessary medical expenses. As defined in the pension program, out-of-pocket medical expenses for other family members would reduce the gross family income for determining eligibility.
   - For NSC veterans whose gross annual family incomes including assets are in excess of double the maximum annual VA pension rate, procedures would be

established by regulation identifying the conditions under which veterans may be considered unable to defray further expenses and VA care could be provided for a particular medical service.

-- Except for veterans requiring emergency care and care in certain extraordinary circumstances, such veterans would not be eligible for VA health care until the veteran's out-of-pocket medical expenses exceed certain levels. These medical expense levels, are termed the "expected medical expense contribution."

-- The expected medical expense contribution would form the basis of a means test procedure to evaluate the veterans inability to defray further medical costs. The following schedular display would be used.

Income Interval as a Percent of Double the Pension Maximum Annual Rate	Expected Medical Expense Contribution as a Percent of Income in Excess of Double the Pension Maximum Annual Rate
100% - 116.7%	25%
116.8% - 133.3%	35%
133.4% - 200.0%	50%
200.1% - 566.7%	75%
566.8% and over	90%

-- If the veteran presented reasonable evidence that out-of-pocket payments for his/her care to private providers and third parties during the preceding twelve months equaled or surpassed the expected medical expense contribution, the veteran would be admitted. The precise evidence acceptable to VA and pertinent to such claims would be defined in regulations.

-- Veterans requiring emergency care and care in certain extraordinary circumstances could be admitted for VA care, but would be billed for the cost of such care up to their expected medical expense contribution. These terms would be further defined in regulation. In addition, the veteran would be billed up to his expected medical expense contribution for any examination provided to determine if emergency care is required.

-- Amend Title 38 to provide that the Administrator shall issue rules on how veterans statements of income and prior medical expenses shall be verified.

-- For treatment of these NSC veterans, if the veteran is covered by a private insurance plan, the private plan would be required to reimburse the VA for medical expenses incurred by the patient that are covered by the plan. The VA would bill the veteran the difference between the insurance company payments and actual VA costs, but not in excess of the veteran's expected medical expense contribution.

4) Waiver Authority

o In exceptional, unusual, and rare circumstances, the Administrator could waive the veteran's expected medical expense contribution.

The Administrator would have authority to grant waivers for a portion or all of an individual veteran's medical expense contribution limited to the period of the episode of care for which the veteran claimed relief. Such waivers would only be considered upon application of the individual veteran, and a demonstration by the veteran that the contribution would effect an unusual and exceptional hardship on the veteran. Such waivers will not be granted categorically, either for categories of illness, expenses, incomes, procedures, or veterans. The Administrator would issue regulations setting forth the procedures for granting such waivers. The Administrator's decision to grant or not to grant a waiver would not be subject to judicial review.

5) Legislation to require reimbursement from a veteran's private health insurance plan.

o Legislation would be drafted to prohibit exclusionary clauses in insurance contracts, effective at the first renewal of such contracts.

- Except for service-connected veterans, VA would examine the family health insurance coverage status of each veteran to whom VA provides care. For veterans so covered, VA would collect insurance proceeds by assignment to the extent such proceeds reimburse VA its actual costs of care.

6) Grandfather

- This new procedure would be implemented prospectively; VA would not apply the means test for patients in a treatment status at the time of implementation of such new procedures. This grandfathering provision would apply only through the duration of the episode of care.

THE WHITE HOUSE
WASHINGTON

BRIEFING FOR THE WOMEN IN HOUSING AND FINANCE

February 15, 1985
10:00 - 11:30 a.m.
President's Briefing Room
Old Executive Office Building

* * * * * *

MARY JO JACOBI, Special Assistant to the President for Public Liaison - opens briefing.

DAVID GERSON, Associate Director of the Office of Management and Budget for Operations and Communications - remarks on FY 1986 Budget and the budget deficit.

Q & A

THOMAS HEALEY, Assistant Secretary of the Treasury for Domestic Finance - remarks on financial institutions deregulation.

Q & A

FAITH R. WHITTLESEY, Assistant to the President for Public Liaison - introduces the Vice President.

GEORGE BUSH, Vice President of the United States - remarks on the FY 1986 Budget and tax reform.

FAITH R. WHITTLESEY - closes briefing.

The President and First Lady thank you for coming to the White House.

* * * * * *

SEEK OTHER MEANS OF SUPPORT BEFORE USING TAXPAYER DOLLARS TO FUND VETERANS HEALTH CARE

- New policies to contain VA health care system costs and reduce eligibility are imperative:
  - Only 50% of current VA hospital users are disabled or poor veterans.
  - 89% of veterans have health insurance coverage, but exclusionary clauses prevent the VA from recovering costs from insurance companies.
  - If current policies are maintained, the number of veterans over age 65 eligible for free VA care regardless of financial means will triple to 9 million by the end of the next decade.
  - VA estimates that annual operations and construction costs will be as high as $37 billion annually to care for these individuals.
- The resources simply won't be there to meet this demand. Any funding shortfall will jeopardize our ability to serve high priority veterans -- the service-connected disabled and poor veterans with no other resources.
- To head off this problem, the Budget proposes that we begin now to sort out our priorities, adjust eligibility rules, and hence limit demands on the system to ensure that highest-priority demands can be met.
  - Free care would continue to be provided for veterans suffering from disabilities incurred while on active duty; and all veterans with incomes below twice the VA pension income standard (currently $18,828 for a family of four.)
  - All other veterans could still receive service at VA facilities on a space-available basis, but would be expected to contribute, to the extent they are able, to the cost of their care -- in most cases, through private health insurance.
  - Legislation will be proposed eliminating exclusionary clauses -- to allow the VA to recover costs from insured patients.
- These changes are expected to reduce inpatient utilization from current levels, lowering system operating and construction costs by more than $7.5 billion over the next 5 years.

NATIONAL ASSOCIATION OF VA PHYSICIANS
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XII Robert W. Conley, M.D.
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TESTIMONY OF
PAUL W. SCHAFER, M.D.
EXECUTIVE DIRECTOR
NATIONAL ASSOCIATION OF VA PHYSICIANS (NAVAP)
AT THE
BUDGET HEARING
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
FEBRUARY 21, 1985

Mr. Chairman and Members of the Committee, as you know, I am employed full-time by the Veterans Administration and serve as Chief of Chest Surgery at the VA Medical Center here in Washington, D.C. In addition to patient care, I carry my fair share of administrative burdens, I am actively involved in basic biological research, and I teach undergraduate medical students and postgraduate house officers. I am academically identified as Professor of Surgery, Georgetown University. Today I appear before you in a strictly unofficial role in respect to the Agency but as a spokesperson for the National Association of VA Physicians (NAVAP) which organization I serve as its Executive Director. We are most appreciative of this opportunity to express the grave concern for the fate of the Veterans Medical Program which I know we share with you. Know that we will lend our support to any and all efforts to defeat those who are now obvious in their attempt to destroy this Program.

For some outside this room who may feel this too harsh a charge, their attention should be directed to the recent brayings of that ex-Divinity School student, excused from military service during the Vietnam War, the present Director of this Administration's Office of Management and Budget. Not long ago David Stockman had the effrontery to attack medical benefits for veterans, and I quote, "who do not even have a hangnail to show for their harrowing experiences in uniform". In recent days he has added active duty personnel to his hit list charging that the Armed Forces care more about their retirement program than about the Nation's security.

It must surely strain the conscience of those who testify in support of this Administration's proposed budget for the Veterans Medical Program. To start off, the proposed real inflation-adjusted dollars in this budget represent a decrease in the funding level which has been without real increase for a decade. This in spite of the Agency's own recently published forecast that the needs of our veterans of World War II and of Korea are peaking and those of our Vietnam veterans are on the rise. Unmentioned is the prospect that more than actuarial statistics may be involved. The Nation's concerns in Central America, Afghanistan, South Africa, the Middle East, and elsewhere have the potential to produce casualties, care for whom would immediately become an obligation of VA personnel and facilities. It is irrational to reduce beds and health care personnel in the face of a documented workload increase and the potential need to serve even more veterans.

A prior Administration's representatives exhorted us to like being lean and hungry - the slogan was, "less is better". This one doesn't even bother. It just proposes fewer beds, fewer staff, less construction, denied care, and a non-viable Veterans Medical Program level which in 1990 would have 14 000 fewer beds, and over 22,000 fewer staff. Its fantasies include a means test, a third party bonanza, and an attitude about the burgeoning numbers of veterans over the age of 65 years which might just as well be expressed by Marie Antoinette's callous observation, "Let them eat cake".

But, Mr. Chairman, aside from dollars in the equation, what of health care personnel morale. This Administration and its minions propose: a 5% pay cut, a Grace Commission recommended grade reduction schedule, a minimum retirement age increase from 55 to 65 with increased penalties for early retirement, decreased cost-of-living adjustments, high 5 rather than high 3 year basis for annuity calculations, elimination of unused sick leave for retirement credit, decreased survivor benefits, and implementation of a health benefits voucher plan.

Almost as if to rub salt in the wound, the Office of Personnel Management has come up with a novel disincentive proposal which defys description. This latest gem is the recommendation that Federal Agencies hire only temporary employees. The proposal is couched in terms of improved efficiency but in fact it is nothing less than an instrument for greater control of the Federal Civil Service and particularly for short-sighted cost savings. Temporaries can be fired without notice, their term of employment is proposed for extension from 2 to 4 years or more, they get no health insurance, and few other benefits. Thus OPM follows the lead of the Housing and Urban Development Department's publication of HUD-0003744 which recommends to cities that they turn public services over to private entrepreneurs since they can hire more temporaries, who can be made to work longer hours, have less leave time, and can be fired at will. The government would get what it pays for: namely, a less motivated and a less competent work force. This is no way to run a railroad.

OPM Head Donald (the not-so) Devine's other novel entry into the privatization sweepstakes race has to compete with such formidable opposition as private-for-profit operation of airports, waterways, satellites, prisons, etc. Devine is now trying to justify the Administration's proposed federal pay cut on the basis of comparing the "quit" rate of federal workers to that of workers in the private sector. This statistical prostitution makes even the Grace Commission's proposals appear falsely to have a modicum of credibility.

Though they don't come out and say it, what this Administration is up to is no mystery. It is explicitly set forth in the recommendations of the influential Heritage Foundation which read as follows, "Congress should eliminate all pensions for veterans and survivors of veterans which are not compensable as 'service-connected'. It is recommended that the present VA health care system be dismantled. VA hospitals and other facilities should be turned over to local governments or private groups where their continued operation is economically viable."

VA-2

This privatization concept is in many ways reflected in the Administration's proposed budget and should be denounced lest it come to full flower next year or the year after. Inexorably increasing influences are already at work in subtle and seemingly complex ways. Among these we can identify the use of Diagnosis Related Groups (DRGs) as the basis for Medicare payments to hospitals in the private sector. An eligible patient diagnosed within a given DRG will have his or her hospitalization paid for out of Medicare funds at a specified dollar amount irrespective of how much or how little care was rendered or how long the patient stayed in the hospital. This will also increasingly be recognized as the basis for paying insurance claims. And no matter how the DRG concept is embellished or what payment formula adjustments are made, the fact is that the level of payment is ultimately determined by one index; namely, length of stay in the hospital, a far too simplistic indicator of complex health care needs, particularly those of patients in their advancing years. We now see the predictable and obvious result. Many private hospitals will not now admit certain patients whose needs can be foreseen to require extended length of stay and if the patient gets in and is later found to require extended hospitalization, enormous pressure is generated to get them out to someplace else, if possible, a VA Hospital. This highly questionable process will surely become the rule rather than the current common exception as health care becomes more of a mega-industry. The Hospital Corporation of America now

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manages 420 owned or leased hospitals; American Medical International owns 160, nine of which were formerly public; National Medical Enterprises owns or manages 132, some of which are public; and Humana owns and leases 87 including the new Louisville City Hospital, the teaching hospital of the Louisville Medical School. More private, public, and yes, medical school teaching hospitals will be gobbled up by the industrial chains....The Golden Arches of Man's in-Humana to Man. To date 30 public hospitals have been sold to hospital chains which lease or manage an additional 150 city and county facilities. It should surely come as no surprise that the profit motive will increasingly become the basis for policy in these hospitals and yes, some if not many of the patients turned away or turned out will be veterans, many of whom never thought they would need to fall back on the hospitals of the Veterans Medical Program. But you can bet your bottom dollar the time is coming when increasing numbers will. This then is another reason to fight now for preservation of a first class system to serve them in their time of need. Veterans will increasingly need modern tertiary care facilities not just nursing homes and domicillaries. Parenthetically it is sad to note that the Veterans Administration has adopted DRGs as a management tool to control the level of funding for its 172 Medical Centers. This is a false yardstick...Where does a veteran go if he does not match the DRG of his Veterans Hospital?

In closing I must repeat what some of you have heard me say before. We have all seen and heard proposals for the Veterans Administration which treat of "free" health care for veterans and which veterans should or should not receive "free" care. Such egregious treatment of the Nation's contract with its veterans deserves nothing less than outraged condemnation. Veterans are not given "free" care, they receive "prepaid" care; care many times paid for with treasure more precious than any exchanged chit of the private medical sector. Veterans' benefits are part of the ongoing cost of war and of the Nation's defense. A Nation which forgets or disregards this contract obligation with its veterans embarks on a journey it will not survive. Were the budget proposals of this Administration to be accepted by the Congress, the Veterans Medical Program projected for 1990 would be found nonviable. Current attitudes concerning privatization strongly suggest veterans would have to rely on free care in underfunded, overcrowded charity wards, and that only if they were lucky enough to find such a charity bed available to them. This is indeed a strange prospect from an Administration that so zealously guards its expenditures for defense hardware, only a few items of which cost as much as the entire annual VA-DM&S budget.

And for one concerned about "hangnails", take it from one whose practice consists solely of veterans with life-threatening illnesses and no place else to turn for help, "He should be ashamed!".....In my line of work there are no hangnails.

TESTIMONY OF DAVID J. PASSAMANECK
Lt. Col., USA, Ret.
NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Before The

COMMITTEE ON VETERANS' AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

On

The VA Budget for Fiscal Year 1986

9:00 A. M., February 21, 1985 - Room 334
Cannon House Office Building

Last year, in our testimony before the Senate and the House Committees we stated:

> The recurrent practice of this Administration of grouping veterans programs with other so-called middle-class entitlements is not only insulting to veterans, but completely inconsistent with the President's obvious sincere concern for the condition of our defense posture. In this connection, the handwriting is on the wall in this budget, with the ominous warning that in order to minimize the need for future tax increases, veterans programs will be subject to "intensive scrutiny."

We are now seeing the results of the "intensive scrutiny," which, as promised by the Office of Management and Budget, are being revealed after the elections. The most outstanding characteristic of the 1986 VA budget, which is approximately $100 million less than last year, is that it represents the first turnaround in a policy of gradual, but steadily improving entitlements and services for veterans and their dependents since the depression of the 1930's. The apparent solution, as far as the Administration is concerned, for the impending 40% increase in veterans 65 and over by the year 2000, with the attendant need for intense development of geriatric care systems, is to cut the heart out of the VA medical program with the immediate objective of removing all but service connected disabled from the rolls of those eligible for VA medical care, and ultimately to provide such care for combat and instrumentality of war disabilities only. This objective was clearly set forth in the concluding discussion on the VA in the by now notorious report of the President's Private Sector Survey on Cost Control (the Grace Commission) whose Chairman, J. Peter Grace, is also the Chief Executive Officer of one of the largest private suppliers of nursing home and other medical services. The same policy objective was reaffirmed by recent White House inquiries of the VA regarding the expected work load if health benefits were limited to veterans with service-connected disabilities.

In addition to recommending a cut of over $150 million in construction funding mostly for improvements to inadequate medical facilities, on the inspiration of David A. Stockman, the Director of OMB, the Administration is seeking legislation to cancel the current space available entitlement to medical care for veterans 65 and older, regardless of economic need, and require all nonservice-connected veterans who were not POW's, and who are not on the pension rolls to pass what amounts to a pauper's test in order to receive medical treatment from the VA. The specific conditions of this so called "means test" remain to be seen, but one version would have veterans paying for the care. No one can say what the limit of these charges would be, but one thing is sure: Millions of sick, elderly veterans would be turned away from VA clinics and hospitals. This same David Stockman, who, in his approach to the budget has demonstrated unmitigated contempt for veterans and retired military is the young man who enrolled in Harvard Divinity School during the Vietnam war in order to avoid military service. In other words, this draft dodger is now leading the assault on military personnel entitlements and veterans programs on behalf of a President who otherwise appears to be sincerely interested in bolstering our national defense posture. As we pointed out when the Grace report was released, even if it could be argued that destruction of the VA medical system, at least as we know it, would save government money, that saving would be at the cost of a revolting betrayal of those of our citizens who have made the most sacrifices for the very survival of our nation. But the tragic irony of the matter is that if the Grace Commission recommendations are followed, health care for veterans on a per capita basis would go up over 10%. Hence, the desire to cut most veterans out of the system.

When confronted with serious questions posed by AMVETS and other veterans groups regarding the cost of implementing the suggested "means test" at the VA's briefing on the budget, the leadership of the VA shrugged their shoulders in bewilderment, but made it clear that the cost of driving millions of elderly veterans from VA facilities would, indeed, be tremendous. Of course, no mention was made of the veterans who, discouraged by the abuse and red tape which would be involved in enforcing the "means test," simply would not even attempt to seek necessary, often preventive treatment to stay the onset of degenerative geriatric conditions. To further impair the ability of veterans to secure adequate health care, the budget also calls for intensive third party collection from insurers, with the resulting sharp increase in premiums and restriction in coverage.

In addition to a proposed destruction of the VA medical system, which would soon disappear without a sufficiently broad patient base, supported by a world class research program, the Administration also seeks to drive millions of veterans from the ranks of home owners by increasing the loan guarantee funding fee from 1 to 5%. This is another brilliant suggestion of the Grace Commission, which will effectively eliminate the no down payment purchase of homes by veterans, or drastically increase the rates of foreclosures.

The plans for the Department of Veterans Benefits, those people with whom the veteran deals in the determination of almost all his entitlements, call for slashing over 4 million dollars and about 700 employees. Also, if the budget cutters have their way, the Regional Offices, as we know them, will be eliminated, leaving in their places some 59 contact offices, with the adjudication, loan guaranty, rating and other administrative functions removed to 3 regional centers. In other words the bureaucracy will be made even more impersonal, with the attendant delays, uncertainties and hardships impacting on the veterans. Hundreds of employees will be removed from most states, and those who do not wish to be uprooted will lose their jobs. The requested appropriation for this consolidation for 1986 is $25,000,000.

Although the Administration proposes a 4.1% cost-of-living increase for compensation and pension, at the same time it seeks to completely undermine the basic quality of VA compensation and pension by subjecting them to the tender mercies of income taxation. The same absurd proposal has been suggested for military disability retirement pay, even for those currently entitled to tax free pay. We commend Administrator Harry Walters for his courageous opposition to this monstrous scheme. We also appreciate the Chairman's and Mr. Hammerschmidt's strong rebuttal on the matter.

AMVETS enthusiastically supports the President's policies regarding the stimulation of the private economy through lower taxes and less government spending in areas where government has no business intruding. National defense, most definitely, including the cost of military personnel, active and retired and the cost of veterans programs is one area where government does have a basic and historic responsibility. When we cut expenditures, the last thing we should do is cut them in this area.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

DONALD H. SCHWAB, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE PRESIDENT'S PROPOSED BUDGET FOR THE
VETERANS ADMINISTRATION FOR THE FISCAL YEAR 1986

WASHINGTON, D. C. FEBRUARY 21, 1985

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the privilege of appearing before this distinguished Committee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab and it is my privilege to serve the more than 2 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

The budget proposed by the President for the Veterans Administration for the fiscal year 1986, which commences October 1, 1985, is $26.7 billion in outlays. This figure represents a decrease of $82 million from the current fiscal year and is 2.7 percent of the Federal budget of $973.7 billion in outlays--the lowest percentage of the Federal budget in recent history.

Ostensibly, Mr. Chairman, this proposed budget represents the Veterans Administration's further contribution to the continuing and elusive deficit reduction efforts of the Administration. In reality, however, we of the VFW view

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it as an unprecedented assault on the Veterans Administration and its hospital and medical care system sugarcoated by a proposed 4.1 percent cost-of-living increase in compensation and pension to be effective December 1, 1985.

We of the VFW support fiscal responsibility. We also support fairness and spending priorities which do not skew intelligent, time honored national priorities. Through the budget reconciliation process, the Veterans Administration and veterans have made a very substantial contribution to deficit reduction. How large a contribution is reflected in the following extract of an article written for our February VFW MAGAZINE by the Honorable G. V. "Sonny" Montgomery:

> "It would be difficult to find anyone who doesn't agree that the Nation's soon-to-be trillion-dollar deficit must be slashed. The Committee on Veterans' Affairs, the Congress, and our veterans and their families recognize and agree that the VA must share in this responsibility, and we will continue to do so. The record shows that the VA has accepted cuts, especially over the last four years.
>
> "In Fiscal Year 1981, the Committee was instructed to reduce budget outlays by $400 million; as a result of, among other things, reduced and delayed COLAs and limitations on the presumption of ability to defray medical expenses, we saved $493 million.
>
> "In FY '82, total reconciliation savings reached $446 million; in FY '83, $602 million; in FY '84, $840 million; and in FY '85, reconciliation savings in budget outlays will amount to $1.69 billion."

Mr. Chairman, the VFW has historically held that any honorably discharged veteran who served on active duty in our Armed Forces during periods of war and hostility and in need of medical care should be provided that care by the Veterans Administration. Most unfortunately, and according to its own survey, the Veterans Administration is presently denying that medical care to over 21,000 veterans each month. Now, this Administration has indicated in this proposed budget that it will callously propose legislation to deny medical care to most veterans suffering from nonservice connected disabilities who are not in receipt of pension or medically indigent by subjecting them to a stringent means test regardless of their age. This is contrary to current law and opposed in the strongest possible terms by the VFW.

The primary function of the Veterans Administration's hospital and medical care system is, of course, to provide care second to none for veterans with service connected disabilities. However, the longstanding intent of Congress to also care for veterans with nonservice connected disabilities was clearly enunciated in paragraph 10, Title II of Public Law 68-242, the "World War Veterans' Act, 1924", which is herein quoted:

> "That all hospital facilities under the control and jurisdiction of the bureau shall be available for every honorably discharged veteran of the Spanish-American War, the Philippine Insurrection, the Boxer Rebellion, or the World War suffering from neuropsychiatric or tubercular ailments and diseases paralysis agitans, encephalitis lethargica or amoebic dysentery, or the loss of sight of both eyes regardless whether such ailments or diseases are due to military service or otherwise, including traveling expenses as granted to those receiving compensation and hospitalization under this Act. The director is further authorized, so far as he shall find that existing Government facilities permit, to furnish hospitalization and necessary traveling expenses to veterans of any war, military occupation, or military expedition since 1897, not dishonorably discharged without regard to the nature or origin of their disabilities: Provided, that preference to admission to any Government hospital for hospitalization under the provisions of this subdivision shall be given to those veterans who are financially unable to pay for hospitalization and their necessary traveling expenses."

More recently, Mr. Chairman, Public Law 91-500 made a noteworthy change in that it amended 38 USC 610 by extending eligibility for hospital, nursing home and domiciliary care to "any veteran for a nonservice connected disability if such veteran is sixty-five years of age or older." To repeal this law, as this Administration intends, and restrict most nonservice connected care to veterans on the rapidly diminishing pension roll and those veterans who are medically indigent does not augur well at all for either veterans or the future of the Veterans

Administration's hospital and medical care system. The retrenchment of medicare benefits and proportionate increases in necessary medicare supplemental insurance would work a severe financial hardship on many veterans and subject others to the vagaries of the floundering medicaid system. According to the House Select Committee on Aging: "The impact of a means test on the veteran would be considerable. The added cost to medicare could be as high as $600 million annually." Curtailing the treatment of veterans will create untoward problems for the entire health care system. Such a mandated continuing reduction in patient load would necessitate reductions in health care personnel, hospital and nursing home care beds and, in the not too distant future, a reduction in facilities and the ability of the Veterans Administration to be a viable primary backup to the Department of Defense. The framework would then be in place to disenfranchise all nonservice connected veterans and contract out care for veterans with service connected disabilities.

Mr. Chairman, the Administration has proposed consolidating into three "benefit processing and support activities" the adjudication of veteran's claims and the maintenance of claim files. The remainder of the 59 VA Regional Offices would become mere contact points where a veteran could do little more than file a claim since no records would be maintained at these points and adjudication of claims would no longer be accomplished at the state level. President Reagan's fiscal year 1982 budget contained much the same proposal. The VFW opposed it then and we oppose it now. Reducing VA Regional Offices to satellite or contact points would greatly hinder the ability of our service officers and other representatives to research and present claims at that level since the claim file would not be available to permit the proper and necessary research. The claimant's access to a full and fair hearing would be restricted since many who would be able to appear before a board in his or her own state might well be unable to travel perhaps half the distance of our country to make a personal appearance. Such hearings as might be held locally would, most likely, be before proxies. All of this represents a serious infringement on the veteran's right to due process, which is already violated by the denial to veterans of the right enjoyed by all other citizens--the right of judicial review. The proposed consolidation would, without question, greatly impede the adjudication of claims and the initial payment of benefits to which the claimant is entitled.

The Veterans Administration's loan guaranty program is the most used veteran's benefit under which nearly 12 million veterans have purchased homes. Public Law 97-253 established a user's fee of one-half of one percent on VA home loans effective October 1, 1982, and terminating September 30 of this year. Veterans with service connected disabilities were exempted and the user's fee when collected went to the Treasury, not the loan guaranty revolving fund. Public Law 98-369 increased the user's fee to one percent until September 30, 1987. Funds presently collected are deposited into the loan guaranty revolving fund. Now the Administration proposes legislation to increase the user's fee from one percent to five percent. In addition, it would obligate purchasers of VA owned property who buy on terms (vendee loans) to either pay a five percent fee, or pay a one percent fee, make a minimal five percent downpayment and obtain private mortgage insurance. The five percent user's fee could effectively negate the value of a VA loan for veterans, particularly Vietnam veterans.

Mr. Chairman, proposed outlays for medical care at $9.05 billion represents an increase of 3.4 percent over this year and, according to the Veterans Administration, offsets the inflation in health care. It is anticipated the requested funding will support the treatment of 1.2 million inpatient and 18.7 million outpatient visits. Medical and prosthetic research is down $36.3 million in outlays and Medical Administration and Miscellaneous Operating Expenses down

$10.2 million. Four million two hundred thousand dollars of the latter is taken from the Health Professional Scholarship Program which will be phased out.

Mr. Chairman, average or full-time equivalent employment (FTEE) within the Veterans Administration's Department of Medicine and Surgery is reflected as 192,048 personnel, an increase of 199 over 1985. However, this increase does not in any way enhance care within the existing system since 2,068 FTEEs are allocated to staff new facilities yet to be activated. In reality, the Administration's productivity improvement program will cut 1,916 personnel and an additional 889 personnel will be lost to existing medical, surgical and psychiatric bed sections. Obviously, more emphasis is being placed on extended care facilities. However, the VA is still not operating the 90,000 hospital and nursing home beds mandated by 38 USC 5010, but 89,100.

Mr. Chairman, a reduced construction budget will permit replacement and modernization of hospitals at Houston, Texas and Mountain Home, Tennessee; a clinical addition and nursing home-care unit at Philadelphia, Pennsylvania, plus nursing home-care units at Amarillo, Texas and Tucson, Arizona; and domiciliaries at Temple, Texas and Wood, Wisconsin. Construction will be delayed for hospitals at Augusta, Georgia; New York, New York; and Philadelphia, Pennsylvania, with the attendant increased cost and possible rescission.

Third-party reimbursement, last proposed in President Carter's fiscal year 1981 budget request to save $315 million per year, has again surfaced in the President's proposed budget but with more modest anticipated savings of $65 million per year. According to the Veterans Administration: "...among veterans hospitalized in VA medical facilities, only 55 percent have some health insurance (including medicare and medicaid), while 45 percent do not." Furthermore, it is suspected veterans with private or public insurance seek VA care only when benefits have expired under their policies. Without delving in-depth into the impediments of this proposal, suffice it to say as far back as 1975, the health-insurance industry indicated paying to the VA the cost of care for a veteran suffering from nonservice connected disabilities would increase premiums by at least ten percent for all policyholders. Most health insurance policies contain an exclusionary clause courts have ruled constitutional and the VA would need to develop and maintain a very elaborate cost-accounting system. Moreover, the VA would need, based upon its own estimate, as many as 2,495 additional FTEEs to handle this extra administrative burden, which obviously the Administration has no intention of providing, in addition to the expanded ADP capability which would be required. This situation is further compounded by the additional personnel required to implement the proposed medical care means test and its corresponding workload.

Mr. Chairman, a most important measure not contained in the President's proposed budget but, rather, in the tax-reform legislation proposed by the Department of the Treasury is the unthinkable, insensitive and ill-advised proposal to tax compensation payable by the Veterans Administration to veterans suffering from service connected disabilities. I cannot foresee this proposal garnering any support in Congress, but permit me on behalf of all disabled veterans to thank those committee members who wrote to the President and the Secretary of the Treasury in this regard. In writing to the President, the Commander-in-Chief of the VFW, Billy Ray Cameron, labeled the proposal "inconceivable."

Mr. Chairman, the reductions proposed in medical care, research, grants for construction of state extended care facilities and major construction flies in the face of the Veterans Administration's report entitled "Caring for the Older Veteran." The challenge is not going to go away. We taxpayers are going to pay for the care of our older veterans. It is merely a question of whether it is to be accomplished with dignity for the veteran and in a cost-effective manner within the VA system or bereft of all dignity through reliance on the almost bankrupt and tenuous medicaid system.

Mr. Chairman, none of us know at this juncture what budget cuts Congress will agree to in the final analysis. However, we of the VFW believe the Veterans Administration and veterans have made substantial contributions to deficit reduction and that the status quo should now be maintained. If the members of Congress believe otherwise, let them speak and be counted. After all, the President proposes, but Congress disposes.

Mr. Chairman, pertinent resolutions passed by the voting delegates to our most recent National Convention are herein listed and appended to my testimony:

Resolution No. 613--"VA Home Loan Guaranty Program"
Resolution No. 688--"Halt to Reductions of Benefits for Veterans and Military Retirees"
Resolution No. 727--"The VA Budget"
Resolution No. 741--"Third Party Payments for Veterans Health Care"

Thank you and I will be happy to respond to any questions you may have.

Resolution No. 613

VA HOME LOAN GUARANTY PROGRAM

WHEREAS, the VFW views the VA Home Loan Guaranty Program as one of the most successful and beneficial programs available to veterans; and

WHEREAS, this popularity is evidenced by the fact that more than 11 million loans have been approved under this program; and

WHEREAS, we are concerned with the solvency and future of the VA Loan Guaranty Revolving Fund; and

WHEREAS, the rapid depletion of this fund due to the high foreclosure and VA property acquisition rate during recent years may soon require an emergent request for additional funding; and

WHEREAS, a "Grace Commission" recommendation would require the VA to change foreclosure proceedings and permit the lender to take possession of the property to reduce VA property inventory and acquisition costs; and

WHEREAS, it is intimated that such a proposal would be cost-effective, in reality it would be more costly to the VA; and

WHEREAS, such an arrangement would ultimately increase the average VA outlay per house from $9,500 to $19,500 and deplete the revolving loan fund; and

WHEREAS, adoption of the Commission recommendation may result in veterans having to make higher down payments, requiring higher income standards primarily affecting Vietnam veterans purchasing their first home; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we urge the Congress and the Veterans Administration to resist all efforts to implement any portion of the Grace Commission proposal that would jeopardize opportunity for home ownership to any eligible veteran.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 688

HALT TO REDUCTIONS OF BENEFITS FOR VETERANS AND MILITARY RETIREES

WHEREAS, personnel having served in the military services of the United States with honor, did so with the understanding they would have certain future "BENEFITS AND ENTITLEMENTS" for that service; and

WHEREAS, many of these perceived "BENEFITS AND ENTITLEMENTS" were presented in the name of the Government of the United States; and

WHEREAS, these same personnel have steadily witnessed a very real and very steady erosion of these "BENEFITS AND ENTITLEMENTS"; and

WHEREAS, the health services and other services under the preview of the Veterans Administration are either being cut back, eliminated, or are under review by the Grace Commission under the pretense of reducing the national deficit; and

WHEREAS, the current PAY CAPS, REDUCTION IN MEDICAL AND HOSPITAL CARE, AND OTHER PROVISIONS FOR LIMITING PAY RAISES TO DISABLED VETERANS AND RETIRED MILITARY are in effect a very real and burdensome reduction for these personnel; and

WHEREAS, many of these personnel would not have invested substantial portions of their most productive years in the military service if they had not fully believed that these "BENEFITS AND ENTITLEMENTS" would be granted them upon honorable discharge or retirement; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that a resounding call for a total and immediate halt to all measures that threaten the current "BENEFITS AND ENTITLEMENTS" of all veterans and retirees be strongly registered; and that the reductions proposed by the Grace Commission for these deserving people be completely ignored; and

BE IT FURTHER RESOLVED, that the Congress of the United States cause a thorough review of the status of past and current "BENEFITS AND ENTITLEMENTS" of both veterans and retirees for the purpose of stopping any further erosion of those same "BENEFITS AND ENTITLEMENTS", and

BE IT FURTHER RESOLVED, that the current pay freezes, pay caps, and reduction in cost of living raises be restored to eliminate any further and undue sacrifices by these personnel; and

BE IT FURTHER RESOLVED, that the Congress of the United States guarantee the future "BENEFITS AND ENTITLEMENTS" of the Veterans and Military Retirees, thereby insuring that those personnel making the sacrifices incurred while serving their country do so with full knowledge and understanding of their future "BENEFITS AND ENTITLEMENTS" upon honorable discharge or retirement, and the so called Grace Commission as pertains to reduction of all veteran's benefits be dissolved.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 688

Resolution No. 727

THE VA BUDGET

WHEREAS, there are presently more than 28 million living veterans of whom over 10 million have reached an age where they require increased health care including longterm care; and

WHEREAS, the Veterans Administration's budget has fallen from 5.1 percent of the federal budget in outlays in 1975 to an estimated 2.9 percent in 1985; and

WHEREAS, the Veterans Administration's portion of federals outlay for health care has fallen from 12.5 percent to an estimated 8.6 percent during the same period; and

WHEREAS, according to the House Veterans Affairs Committee, "there is evidence that an artificial 'cap' has been placed on the resources available for outpatient treatment, resulting in a denial of treatment to eligible veterans in some cases, and in other cases resulting in an inappropriate admission as an inpatient," an opinion shared by the Veterans of Foreign Wars; and

WHEREAS, in its report to the budget committee the House Veterans Affairs Committee stated, "...it appears that the facilities which the Veterans Administration presently operates, and which it plans to build or renovate with the funds requested in its 1985 budget, will not accommodate by any measure, the anticipated demand for services over the next 20 years"; and

WHEREAS, the Administrator of Veterans Affairs was quoted in the May 15, 1984 edition of U.S. Medicine as saying that by the year 2000, a 68 percent increase in hospital beds will be needed with special geriatric evaluation units at each medical center, and that outpatient clinics should be able to support 26 million visits with appropriate prevention and geriatric and specialized services and that 30 Geriatric Research, Education and Clinical Centers (GRECCs) should be established by 1990; and

WHEREAS, veterans who served honorably in our Armed Forces during periods of war and hostility have rendered a very special service to our great nation and if in need of health care should be timely provided the finest care by the Veterans Administration, now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we prevail upon the Congress of the United States to pass a budget and appropriation for the Veterans Administration which will fully fund and maintain the integrity of the benefit and entitlement programs and an enhanced Veterans Administration hospital and medical care system.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 741

THIRD PARTY PAYMENTS FOR VETERANS HEALTH CARE

WHEREAS, the Veterans Administration Department of Medicine and Surgery is charged by law and tradition with caring for the Nation's veterans; and

WHEREAS, the veterans of this country are entitled to hospitalization, nursing home care, outpatient treatment and other related health services for the many sacrifices made during service to their country; and

WHEREAS, under the Constitution of the United States of America, the several States are reserved the power to regulate their industries and commerce; and

WHEREAS, the Nation's insurance industry is wholly controlled under laws and regulations administered exclusively by the several States; and

WHEREAS, most health insurance policies contain exclusion clauses which prohibit payment for medical care provided in Federal medical facilities; and

WHEREAS, any Federal legislation granting the United States or any of its agencies the power to collect funds for private insurance companies is unconstitutional; and

WHEREAS, implementation of such a program would require additional appropriated funds and the recruitment of many additional VA staff. This magnitude of resources can be better spent in the direct care and treatment programs of the Department of Medicine and Surgery; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we unalterably oppose any Congressional enactment of legislation empowering the Veterans Administration or any other agency of the United States Government to collect funds from private insurance companies to defray the costs the Nation incurs to care for its veterans excepting beneficiaries covered by Section 629, Title 38, US Code

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984

Statement of

The American Legion

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WASHINGTON, D. C. 20006

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

on

FY 86 BUDGET

FEBRUARY 21, 1985

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FEBRUARY 21, 1985

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to present its views, following an initial appraisal of the Administration's proposed Budget for the Veterans Administration for Fiscal Year 1986.

It must be said at the outset that we are aware the Administration is seriously concerned about the ominous budgetary deficit that faces the Federal Government. Veterans have shared that concern and during the immediate three previous fiscal years have acceded to reductions in veterans programs that have amounted to, on the whole, more than $500 million. Most of these adjustments, when proposed, were accepted by The American Legion, because we represent the nation's veteran population, and veterans are responsible citizens. When all entitlement programs were being modified, we believed that veterans must do their share - and we have done just that.

Additionally, the portion of the total Federal Budget consumed by veterans programs has been steadily shrinking over the past ten years. In FY 1975 the VA Budget represented a full 5 percent of the total Federal expenditures; in FY 1981 - 3.2 percent, and in FY 1985 - 2.7 percent. Thus it cannot be said that veterans are receiving more than their fair share of total Federal dollars when in fact just the contrary is true.

The American Legion believes that any further reductions in funding for veterans programs would prove seriously harmful to the most needy and deserving beneficiaries of programs administered by the Veterans Administration.

For Fiscal Year 1986, the President has proposed for the Veterans Administration, Budget Authority of almost $27.110 billion, down $123.6 million from FY 1985, and Budget Outlays of nearly $26.729 billion, down over $82.3 million from FY 1985.

The American Legion stands for full funding for veterans programs; by which we mean there should be provision of such funds as are necessary to effectively carry out the programs that have been established by Congress. We support all those programs. Each of them had a purpose when enacted, and each was adequately justified as meeting a legitimate need of the veteran population. We are not aware of any programs at present that are superfluous or redundant; and therefore we support all veterans assistance programs that are now functioning.

The fact is, Mr. Chairman, The American Legion does not feel the proposed funding levels for FY 1986 are satisfactory to effectively carry out all of the programs administered by the Veterans Administration. The budget proposal provides no overall increase in spending, and contains initiatives that would adversely affect thousands of America's veterans, their dependents and survivors.

Before providing comment on several specific budget items, which will be done in reference to the departments of the VA that administer them, we shall first address the legislative proposals set forth in the Budget Message.

LEGISLATIVE INITIATIVES

The Administration recommends a cost-of-living adjustment of 4.1 percent in compensation to be effective December 1, 1985. It is the position of The American Legion that these COLAs should be at least consistent with increases in the Consumer Price Index. The proposed 4.1 percent increase in benefits for the service-disabled, who are the most deserving of all Federal beneficiaries, is consistent with the current rate of inflation.

An increase in the loan origination fee from 1 percent to 5 percent on all guaranteed and vendee loans is proposed. The American Legion is opposed to this increase. In practical effect, it would eliminate the advantage of enabling a veteran to purchase a home with no down payment.

Another loan guaranty proposal would allow for borrower/lender negotiated rates on guaranteed and vendee loans; and terminate the Administrator's authority to set interest rates. We oppose this action, as it would drive interest rates up, and put veterans out of the housing market.

The third initiative relating to the home loan program would repeal transfer authority from the Direct Loan Revolving Fund to the Loan Guaranty Revolving Fund, and the Legion opposes this move because over the past several years foreclosures resulting in part from high unemployment have depleted the Loan Guaranty Revolving Fund, and the ability to transfer funds from the Direct Loan

Revolving Fund has kept that fund solvent.

Proposed legislation would repeal the authority that permits VA to make education loans. Although an earlier cost-savings measure, the Omnibus Budget Reconciliation Act of 1981 (PL 97-35), limited the number of individuals eligible for VA education loans, those who retain eligibility and who depend upon these loans could be forced to discontinue their program of education or training. Thus, we oppose this initiative.

Another proposal would effect reimbursement from third party insurance carriers, for cost of medical care and treatment to veterans with nonservice-connected disabilities, effective October 1, 1985. The American Legion is mandated to oppose third party reimbursement for several reasons, the primary one being that in essence veterans would be paying for their VA medical care through health insurance premiums. If third party reimbursement were implemented the VA health care program would be changed in its essential nature from a benefit to a cost-sharing medical plan. The American Legion believes if that were to happen, we would find it difficult to defend the program against vouchering or mainstreaming. The projected savings resulting from third party reimbursement is $65 million, and quite frankly, we fail to see how that could be an accurate figure. We have heard statements made by VA officials during Congressional hearings to the effect that the administrative costs necessary to implement the mechanism for collection of insurance payments would probably exceed the costs that are recovered. Such reasoning seems logical when considering

the majority of nonservice-connected veterans using the VA system are probably not covered by insurance, and that complicated problems involving cost formulas, quality controls and distribution of services would have to be resolved before third party reimbursement legislation could be implemented.

The Administration is also proposing legislation to establish income criteria for medical care eligibility (means test) for nonservice-connected disabled veterans regardless of age. This proposal would, among other things, rescind 38 USC 610(a)(6), a provision of PL 91-500 authorizing that the Administrator, within the limits of Veterans Administration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to any veteran for a nonservice-connected disability if such veteran is sixty-five years of age or older. It would also rescind section 401 of PL 96-330, a provision calling for VA to require evidence of inability to defray necessary expenses from nonservice-connected veterans under age 65, which has not been implemented as of this time. It has not been implemented because of problems as between VA and OMB in developing a testing formula that would be fair to all parties, especially the veteran, and that would not create administrative burdens that would outweigh the monetary gains to be achieved. Whether or not it remains true presently we do not know, but at last report we were informed by VA there would be no additional FTEE provided to the VA medical centers to administer the means test, if implemented.

The American Legion would not support a means test for nonservice-connected veterans regardless of age. We believe it would prove to be ineffective because available information indicates that most of the veterans that use the VA medical care system are old, sick and poor. If forced out of the VA system these veterans would have to resort to Medicare, Medicaid, or to other publicly supported institutions.

One of the primary reasons for the implementation of subsection 610(a)(6) of the title was the fact that nearly every veteran age 65 and up is eligible for Medicare. The legislative history of PL 91-500 shows that at the time the legislation was being considered, the cost of the provision of treatment under Medicare was higher than the cost of care by VA. It was estimated that savings to the Federal Government would exceed $8 million during FY 1971 because veterans were treated by VA and not under Medicare. Current available figures reflect that the average daily cost of treatment in a VA facility is still less than the average daily cost of care provided through Medicare.

The implication that the VA system is crowded with affluent veterans is a myth. It is the earnest suggestion of The American Legion that before any consideration is given to this proposed legislation, the Committee should require from VA an updated profile of the current patient population of the VA system. If, as we believe, such a profile demonstrates that the veterans using the system are overwhelmingly old and poor, then the question has to be answered, why establish another administrative mechanism that will accomplish nothing.

DEPARTMENT OF VETERANS BENEFITS

The direct benefit programs administered by VA through the Department of Veterans Benefits will consume 59.3% of the total VA Budget. These are, for the most part, the entitlement programs that must be funded, and they are meeting the real needs of the veteran population they are intended to serve.

These benefits are currently administered through 59 regional offices and, Mr. Chairman, as you are well aware, the Office of Management and Budget has proposed, and VA is beginning action on, a planned reorganization and consolidation of field office functions of the Department of Veterans Benefits. The plan is to consolidate DVB benefit and support activities into three regional centers. Activities included would be adjudication of compensation, pension and education claims; loan processing, and support services, including administrative, finance, and personnel functions. The only services that would remain at the regional offices are veterans benefits counselors, vocational rehabilitation and counseling personnel, compliance survey, and some loan guaranty activities.

The proposed consolidation would be carried out over three fiscal years - 1986 through 1988 - at a cost of $85 million.

This proposal is reminiscent of the "midnight massacre" of March 1981, when OMB announced that DVB was to lose over 1600 employees and a proposal surfaced to consolidate the majority of the operations of the VA regional offices into one or a maximum of three centralized locations. Fortunately, that proposal was short-lived.

Mr. Chairman, the proposed concept would eliminate direct service to veterans who are attempting to develop claims for benefits by denying the claimant the opportunity to present his or her claim in person, and with the assistance of a veterans service organization. The individual veteran needs and deserves this opportunity.

The American Legion is totally opposed to the planned consolidation and reorganization, as we consider it as neither reasonable nor practical.

An additional, but congruent matter of concern is the proposed reduction of 624 FTEE in DVB. Although this loss of personnel is designated as "savings through consolidation" in the Budget Message, it is consistent with reductions of FTEE in the Department of Veterans Benefits over the past several years.

The proposed reduction would bring average employment in DVB down to 12,894. This loss is superimposed on previous reductions, through FY 1985, of 4,558 FTEE since FY 1979. We must advise the Committee that we are concerned about the effect of these losses on delivery of services to VA beneficiaries. The timely delivery of benefits to veterans, their dependents and survivors is an important responsibility of the Department of Veterans Benefits, and the quality of work performed by personnel assigned to DVB, determines to a great extent whether beneficiaries do in fact receive the benefits to which they are entitled by law. Consistent and persistent reduction of personnel will inevitably impact on the ability of DVB staff to complete action on cases and disburse benefits. The American Legion's concern is projected from the standpoint that VA beneficiaries are either the service-disabled, their survivors, or the aged and infirm seeking pensions. All are persons who very much need the benefits they are seeking, many on an urgent basis.

Aside from the proposed consolidation, VA management attributes the reduction to declining work loads and management actions to reduce overhead and increase productivity. We respond that although the case load is in fact declining, the complexity of claims has increased due in part to issues such as the effects of exposure to Agent Orange and radiation, and the pathology of Post-Traumatic Stress Disorder, thus requiring more man hours per case. The Legion is certainly supportive of economy of personnel in management, and maximum productivity by all Federal employees. However, a certain minimum of personnel is needed to properly process cases, without delay-causing errors that have to be corrected; and productivity can only be used as a relative guide when considering the volume of paper work that must be done in the processing of a single case for award of benefits.

We believe the Committee should press for precise data and information from VA before effecting further loss of field personnel in DVB, and we strongly recommend active oversight during the year to ensure prompt delivery of benefits.

DEPARTMENT OF MEDICINE AND SURGERY

There is no question that the most sensitive area of the Budget for the Veterans Administration is the medical care program. This is because, unlike the entitlement programs that are statutory in nature, the strength and efficacy of the medical care program depends directly on the allocation of funds by Congress.

The Administration proposes more than $9 billion for medical programs in FY 1986, representing 35.5% of the total VA Budget. Although this is a projected increase of $236 million over FY 1985, much of this is consumed by normal payroll increases and inflation.

We note that the average employment in DM&S will increase in FY 1986, by 199 to 192,048. However, upon close examination of the figures for average employment we see included therein a reduction of 889 FTEE in existing medical centers, and the loss of 1,916 FTEE due to Government-wide and management reductions. The American Legion is opposed to any reduction that would impact on health care professionals. Based on our monitoring of the Department of Medicine and Surgery through site visits by Legion Field Representatives to more than 65 medical centers each year, we can attest that every one of the personnel assigned are needed. The staff to patient ratio in tertiary VA medical centers is lower than in private sector hospitals, and much lower than will be found in university hospitals.

The proposed medical work loads for FY 1986 reflect no change in the number of inpatients treated in VA hospitals, which is projected at 1.4 million for the year. There is an allowance for an increase of 112,000 outpatient visits to almost 18.8 million, which we consider badly needed. It is estimated that over 21,000 veterans a month are turned away from outpatient clinics.

The maintenance of average operating beds in the VA system reflects a loss of 1,000 acute care beds and 100 domiciliary beds, and an increase of 700 nursing home beds for a net loss of 400 beds. The loss of 1,000 acute care beds is deeply disturbing to The American Legion, particularly when considering the fact that VA faces the prospect of 7 million World War II veterans passing age 65 by 1990.

We have offered precautionary comments over the past several years, that in our judgment there should be no further reduction of acute care beds within the system. However, since FY 1981 3,500 acute care beds have been eliminated - and that does not include the decrease of 1,000 beds proposed for FY 1986. This is a particularly bad time to be eliminating acute care beds, when aging veterans are experiencing more catastrophic illnesses. Older persons ordinarily require care for an acute episode before passing to the need for long-term care. Thus, while the need for more long-term care beds in the system is clearly, demonstrable, that need by itself does not connote a decreasing need for acute care beds. The Veterans Administration must maintain a substantial number of acute care beds if it is to retain its ability to treat the full mix of treatment needs required of it by its primary mission, and its ability to fulfill the agency's latest assigned mission as the principal contingency back-up to the Armed Services medical programs in case of an outbreak of hostilities.

We do approve of the proposed increase of 700 nursing care beds, to 11,500. Nursing Home Care Units in the VA system are always used to capacity, and most of them have waiting lists. A consistent increase in nursing care beds is strongly indicated.

Of extreme concern to The American Legion is the absence of any reference whatsoever in the Budget Message to several important medical programs, beginning with inpatient Post-Traumatic Stress Disorder units. PL 98-528, the Veterans Administration Health Care Amendments of 1984, was enacted in October, and provides for badly needed improvements in the diagnosis and treatment of PTSD. Provisions include authorization for the Chief Medical Director to designate special programs for the treatment of PTSD; a requirement that the CMD establish a Special Committee on PTSD in the Department of Medicine and Surgery; a provision that directs the CMD to establish and operate a National Center on PTSD to conduct and promote research and training on the diagnosis and treatment of veterans with PTSD, and to serve as a resource center for coordination and exchange of information on research and training with respect to the disorder. The law also requires the Administrator to submit to the Veterans Affairs Committees, detailed reports on, among other things, a description of resources allocated to each PTSD program, and an assessment of the VA's capacity to meet the needs of certain veterans for PTSD diagnosis and treatment and any plans, including costs, of increasing that capacity. The first report is to be submitted not later than March 1, 1985. Not later than February 1, 1986, and February 1 of each year for the following three years thereafter, the Administrator is to submit to the Committees a report updating those previously submitted.

With respect to the portions of these reports relating to the allocation of resources for PTSD programs, treatment and research, the first report is to include information with respect to allocations made for FY 1986 and expenditures for each prior year. As stated earlier, we find no reference to any funds being allocated to the treatment of PTSD for FY 1986 in the Budget Message.

In addition, The American Legion has strongly advocated the continued development of innovative treatment modalities that will relieve pressure on acute care sections of VA medical centers. Here we are talking about such things as Ambulatory Surgery, Hospital Based Home Care, Adult Day Care Centers, and Geriatric Evaluation Units. We find no funding allocated to these programs in the proposed Budget. We are also fully in support of the development of the hospice and respite care movement within VA, and no funding is provided for these programs.

The American Legion considers all of these innovative modalities as part of an integrated health care program, and feels that funding must be provided for each of them.

Medical and Prosthetic Research

A decrease of $5 million, down to $187 million, in research funds is projected for FY 1986, and this is not acceptable to The American Legion.

The Medical and Prosthetic Research Program in the Department of Medicine and Surgery is a matter of special concern to us. This is because we are keenly aware of the importance of research in the triad of the VA health care program: clinical care, education of health manpower, and research. None of the three elements can thrive without the presence of the other two. It is a known fact that VA cannot continue to provide high quality medical care to veterans without a strongly funded research program. Much of the research in which VA engages is basic research that is advantageous not only to veterans, but which advances medical science and is of direct benefit to all mankind.

Equally important is the fact that a strong and viable research program ensures the recruitment and retention of high quality physicians into VA service. This fact was proven during recent years, when serious underfunding of VA research led to the loss of many good physicians who took employment elsewhere so they could pursue research. We trust the Congress will not let such a situation develop again.

The decrease of $5 million is alarming. Also projected is a loss of 157 research personnel which would bring the systemwide total down to 4,348. We do not know how these reductions will be accomplished, but we are extremely concerned, because we see a need not for a reduction, but rather for an increase of available personnel for the research activities. The Federal Government could not spend any of its funds any more wisely than on a vigorous and viable VA research program, that benefits the entire American people. The increase in research funds for FY 1985 was encouraging. However, the proposed reduction may be viewed as a serious threat to the program.

Geriatric Research Education and Clinical Centers (GRECCs)

We are concerned at the fact that there are no funds in the VA Budget for further expansion of the GRECC program.

Public Law 96-330, approved August 26, 1980, authorized the establishment of seven GRECCs in addition to the eight then functioning. In FY 1984, VA requested and received funding to establish two additional GRECCs. At that time it was explained to us that VA would request funding for two additional GRECCs each year until the seven authorized were operating, for a total of 15, as authorized by PL 96-330.

Additionally, a provision contained in PL 98-528 made permanent the authorization of appropriations to support the research and education activities of the GRECC program in Fiscal Years 1985 and beyond.

The fact that in FY 1986 there is again no proposed funding for expansion of the program is discouraging. We believe that any further delay in establishing the authorized GRECCs will be unfortunate. These centers of excellence are doing extremely valuable work in all three fields of clinical care, education of health professionals in aspects of geriatric medicine, and in basic research on such conditions as various forms of cancer and Alzheimer's Disease. It is obvious that with the nation's aging population, and increased longevity, there is a desperate need for more knowledge about Alzheimer's Disease. With encouragement and needed funding there is a possibility for VA research to lead the field in this particular disease, before it becomes a health problem of epidemic proportions.

We would appreciate the Committee's consideration of adjusting the VA Budget to include funds for, and instructions to VA to proceed to establish another one or two GRECCs during FY 1986.

Grants for Construction of State Extended Care Facilities

The Budget Message proposes a reduction of $13 million, down to $22 million for grants for construction of State Extended Care Facilities.

The American Legion is very much aware that the services provided by State Homes have greatly reduced the burden that otherwise would have been borne by the Veterans Administration, and when considering the current efforts to reduce Federal spending, the role of the State Homes becomes even more significant.

The FY 1986 request will provide for four projects which will produce 450 additional nursing home beds, and 126 convertible (domiciliary/nursing home) beds. Additionally, these resources will support one life safety project and eight remodeling projects.

However, we are informed there is now a backlog of 66 projects representing requests for grants of $165 million - and the list is growing almost daily. What this means is that if a State submits a request for a grant for funding of a project today, it may receive funds five to six years in the future.

The proposed decrease of $13 million translates into funding for fewer requests in FY 1986. As we move into the period of an aging veteran population that will be with the nation for the foreseeable future, the States can be of major assistance to the

Federal Government in caring for this population through State Homes and extended care facilities. However, in order to materially ease the pressure on the resources of VA, adequate funding must be provided to the States so that proposed projects may be completed.

The American Legion does not feel that the proposed $22 million is sufficient for the funding of grants for construction of State Homes, and this position is based upon the backlog of requests. Many States are moving very positively to make provision for their aging veteran populations, a fact that is most commendable. However, it deserves the full support and encouragement of the Federal Government. This program is a most cost-effective way for the Federal Government to meet its obligation to veterans.

Grants to the Republic of the Philippines

The Budget proposal provides a grant of $500 thousand to the Veterans Memorial Hospital in Manila. This grant has been made by the United States consistently since the end of WW II. The Veterans Memorial Hospital cares for many Filipino veterans who served in the Allied cause during WW II. There is certainly an obligation by this country to continue to show our gratitude and concern for them. The American Legion has always supported this grant, and continues to do so.

MEDICAL CONSTRUCTION

In the Administration's Budget, the medical construction program is recommended for a reduction of $154.9 million down to $712.9 million, for FY 1986. And that figure includes $160 million in prior budget authority that is being reprogrammed from the major working reserve.

We realize this is the second largest construction budget in VA's history, the largest being in the current fiscal year. However, we question the wisdom of reducing the funding for medical construction when the capital plant of the VA health care system is deteriorating. The reasons for this deterioration are manifold; one of them being serious underfunding of this program for several years until recently. This means VA is playing catch-up with its capital plant renovation and replacement program. The facilities have aged more while nothing was being done, and costs have escalated. It has been a losing proposition all around. Finally, the Government has been trying to make up for lost time, and it is costing a lot of money, but it is still a good investment. As we have said many times, the capital plant of the VA system is a multi-billion dollar investment by the Federal Government, and it must not be allowed to deteriorate.

We have preliminarily reviewed the replacement and renovation projects scheduled for FY 1986, and based on the reports of our Field Representatives who make site visits to all of these facilities, we can assure the Committee all of the work scheduled is needed, and much of it is long overdue.

We are pleased to see funding provided for work on a clinical addition, renovation, parking and a 240-bed Nursing Home Care Unit in Philadelphia; and for replacement and modernization at the VAMC Houston.

We do have two particular areas of concern we wish to mention.

First is the issue of the replacement hospital at Baltimore. The need for a replacement hospital in Baltimore has long been established, and, in fact, construction had begun when the President included the funding for this construction in a recession message in 1981.

In August 1984 VA requested a $2 million increase in the Advance Planning Fund in the FY 1985 Budget request for use in determining the most appropriate approach to modernizing the medical centers at Loch Raven and Fort Howard. As a result of that request, Congress provided the $2 million and directed VA to add the alternative of a new replacement medical center to the modernization of the two facilities. A planning report on this is scheduled for completion on April 1, and it will reportedly recommend the best course of action. Regardless of the recommendations contained in the report, we have been told that implementation of any proposals would not be possible until FY 1988 or 1989.

The American Legion strongly recommends a replacement hospital in Baltimore. We have seen evidence where veterans who could have benefitted from inpatient treatment at VAMC Baltimore, have been placed in ambulatory care programs in order to meet, as well as possible, their medical needs. We understand that the medical center has been forced to admit only those veterans suffering from the most severe acute illnesses, for which hospitalization is absolutely necessary. In addition, we have learned that due to constraints on resources and space, major elective surgery cases have been delayed. The American Legion feels that a replacement hospital needs to be built and should be built. We hope the Committee will give this serious consideration.

Our second concern is the 60-bed nursing home that was proposed for construction at VAMC Providence, Rhode Island. At the request of the Chairman, Subcommittee on HUD - Independent Agencies, Senate Committee on Appropriations, the General Accounting Office issued a report dated May 15, 1984, subject of which is titled "VA Justification for Two Nursing Home Care Construction Projects in its Fiscal Year 1985 Budget Request." The report states that the project at the Providence VAMC does not appear to be needed. The report goes on to say that VA did not adequately consider local needs and resources which indicate that the Providence area will have an ample supply of community and State Home beds to meet veterans nursing home needs in 1990. According to the report, on May 11, 1984, the Acting Chief Medical Director advised GAO that he had recommended to the Administrator that the project be deleted from the VA's Fiscal Year 1985 Budget request.

The American Legion disagrees categorically with the information released by the General Accounting Office that the VA assessment of the need for nursing care at Providence was not sustainable. We have been in frequent communication with the Rhode Island American Legion, and our information from that organization is contrary to the GAO Report.

A site visit report by an American Legion Field Representative covering the period September 5-11, 1984, states in its conclusions that the needs of the aging veteran have been brushed aside by the

Providence VA Medical Center. The report goes on to say that "the nursing home needs of the veterans within the Primary Service Area (PSA) of the medical center cannot be met today. If a 60-bed NHCU was opened today on facility grounds, it would be at full occupancy within a month. During the course of this survey, 55 veterans were placed in 28 contract nursing homes from this facility. This did not include 30 placements from the New Bedford area. Also, the waiting list was estimated at between 20-25. Exact figures regarding the waiting list were not revealed to this surveyor." The report continues by stating that no further placement could be done at that time because there was no funding available since it was the end of the fiscal year. The waiting period for veterans was reported by VA staff as only two to three weeks, but the Commandant of the Bristol State Home stated his waiting list included approximately 60 applicants and the waiting period was between six to eight months. The surveyor felt as a result that the figures offered by VA staff were suspect.

Statistics from DM&S show that in FY 1983, 22,340 veterans resided within the Providence PSA between ages 65-74, and 6,886 were age 75 and older. It is estimated in FY 1990, 39,749 veterans will be between the ages of 65-74, and 10,824 will be age 75 and older.

Figures obtained from the Rhode Island Department of Health and used by GAO in support of its report reflect that providers plan to develop 1,098 additional nursing beds within the next five years either through expansion or new construction. The Providence

Medical Center Director advised our Field Representative that it is certain that by the Spring of 1985, 432 additional beds will become operational and quite likely that 120 more beds will be developed by late 1985. It must be pointed out that if in fact the proposed 552 beds were constructed in the private sector, they would be for use of all citizens of Rhode Island, not just veterans. However, we seriously question the proposed number of beds, and particularly those proposed for 1985. As of September 11, 1984, the date on which our Field Representative left Providence, not one construction project had started within the State.

Recommendation No. 1 contained in the Field Service Report recommends that funding for construction of a 60-bed NHCU be approved, and that the project be given top priority.

Mr. Chairman, on the basis of the Field Service Report and the information provided to us by the Rhode Island American Legion, we wish to reiterate at this time the support of the National Organization of The American Legion for the construction of a Nursing Home Care Unit at VAMC Providence. We are satisfied the unit is needed to provide care for veterans in the Primary Service Area of that VAMC. We believe the data assembled by the General Accounting Office is not accurate or correct, and does not demonstrate an understanding of the needs and problems of the aging veteran population of the Providence area. Our recommendation to the Committee is that funding for the unit be included in the FY 1986 Budget.

Beyond these two special areas of attention, we wish only to reiterate our concern regarding the wisdom of the proposed reduction in medical construction funding at a time when VA is playing catch-up with its capital plant renovation program.

As we have previously stated to the Committee, in a sense the expenditures in this budget area are capital investments, and should not even be included in the total Federal funding that is leading to such high deficits. There is a school of thought in the Congress itself that the capital investments and expenditures of the Federal Government should be identified separately as they are in most business operations.

DEPARTMENT OF MEMORIAL AFFAIRS

The funding request for the Department of Memorial Affairs reflects a slight increase of $97 thousand to $44,269 million for FY 1986. An additional $18.9 million is identified for cemetery construction projects which is up $1.8 million from FY 1985. The American Legion feels that this funding appears adequate. We totally support the construction program that is underway, and which includes the Ft. Mitchell National Cemetery, scheduled to open in the Fall of 1986; the development of 13,000 gravesites and construction of an administration building at Withlacoochee, Florida; and the proposed land purchase in Northern California. We continue to work with the Department of Memorial Affairs in attempting to acquire land for the expansion of existing national cemeteries.

The total Memorial Affairs program, we believe, is progressing in a satisfactory manner. It is the perception of the Legion that the program has improved immeasurably since it was placed under VA jurisdiction. We commend the progress that is being made, and trust that the Congress will continue to support VA's plans with the modest funding needed for this program.

ECONOMIC CONCERNS

Mr. Chairman, The American Legion also has several concerns regarding programs for veterans operated by agencies other than the VA. While some of these programs may not fall within the strict parameters of this Committee's jurisdiction, they nevertheless deserve this Committee's attention.

Within the Department of Labor there are a variety of programs for veterans operated under the direction of the Assistant Secretary of Labor for Veterans Employment and Training (ASVET). The American Legion is generally pleased that the proposed FY 1986 budget for the operation of DoL programs contains no significant cuts. However, it must be understood that any cuts in these programs will be felt more deeply because these programs are already operating on a bare bones budget.

For example, an 8 percent cut in travel funding for the Veterans Employment Service, as contemplated in the FY 1986 budget, can be expected to significantly hamper the efforts of State Directors of Veterans Employment in the execution of their outreach responsibilities. Another example is the cut in funding for the veterans portion of the Job Training Partnership Act (part IV. c.) from $9.7 million in FY 1985 to $7.7 million as proposed for FY 1986. In this case, already limited funding for those participating grantees in the States is having an affect on the number and quality of services provided. Further cuts will have a predictable and negative impact.

In another area, the FY 1986 budget contemplates unhitching State Employment Security Agencies, otherwise known as the job service, from the Federal Government altogether by FY 1988. Given the fact that State and Regional Directors of the Veterans Employment Service as well as Local Veterans Employment Representatives and Disabled Veterans Outreach Program Specialists all base their operations in local job service offices, a proposal allowing the devolution of the job service has to be viewed with considerable foreboding. Apart from the rationale used to support this proposal, the most obvious and immediate question that remains unanswered is, what will become of employment services to veterans if the proposal is implemented. In the absence of any clear and convincing assurances that these services for veterans will continue as an on-going Federal obligation to veterans economic readjustment, The American Legion must oppose this proposal.

In another agency, the Small Business Administration (SBA), the FY 1986 budget proposes complete disolution. Regardless of the reasoning behind this proposal, it is important to recognize that it is only in the last few years that veterans have been able to benefit from programs long on the books.

It is only recently that SBA has been providing veterans with the special consideration in their applications for loan guarantees as provided by law for many years. After having been ignored for so long, this law has finally been translated into positive gains that have been good for the general economy, the veterans served and the individuals having become taxpayers because of the jobs created by newly established small businesses.

On Balance, the gains made by veterans recently are too significant to be allowed to be reversed. In Fiscal Year 1984 alone, 26.5 percent of all SBA lending dollars (including either direct loans or loan guarantees) went to veterans. Between 13,000 and 15,000 veterans attended SBA seminars and workshops around the country. Another 8,360 veterans received general business counseling and some 93,893 veterans received in-depth business operations instructions.

FEDERAL BUDGETARY TRENDS

After having outlined our objections to those cuts in veterans programs contained in the proposed budget for Fiscal Year 1986, we feel it is incumbent upon us to offer an additional perspective from which to assess the fiscal merits of veterans programs and thereby justify the size of the budget for veterans needed.

As stated early on in this statement, VA has consumed a shrinking share of total Federal spending. The reasons for this are probably several, but there is one very important reason that must be understood clearly. Unlike most entitlement programs, VA programs generally, and readjustment programs specifically, are not open-ended. Instead, they have built-in efficiencies which guarantee precipitous declines in costs. The G.I. Bill education program is a classic example. In FY 1975, the cost of VA education was $4.6 billion. In FY 1984, the cost of VA education was only $1.4 billion. By contrast, the Federal contribution to programs operated by the Department of Education such as Pell Grants, National Defense Student Loans and others over the same period has increased enormously. In our judgment, this is but one example of why it is unwise to hold out the VA budget for cuts on the dubious assumption that fairness somehow dictates that VA must contribute even more than it already has to overall efforts to reduce the Federal deficit. The fact is that VA's budget has always been lean and as such has already been contributing to fiscal cost containment for years.

In another example comparing the growth of entitlements, the cost of the Comprehensive Employment and Training Act (CETA) in Fiscal Year 1975 was $4.1 billion. Under the Job Training Partnership Act (JTPA), the Fiscal Year 1984 cost was $5.1 billion. Even though CETA was replaced with the much more fiscally prudent JTPA, the Federal cost of employment and training increased significantly. By contrast, employment and training programs for veterans have always been limited in both scope and cost and have been carefully tailored to narrowly drawn targeted groups of veterans.

In medical care, VA spending between Fiscal Years 1975 and 1984 rose from $3.7 billion to $8.8 billion. Though this constitutes an increase of 138 percent, the cost of Medicare spending during the same period rose from $12.9 billion to $62.0 billion;

an increase of 380 percent. In the private sector, medical spending between Fiscal Years 1975 and 1984 rose from $66.6 billion to $215 billion, or 323 percent.

With this in mind, the cumulative increase in the Consumer Price Index (CPI) from 1975 through 1984 has been 111 percent. Overall VA spending over the same period has risen only 55 percent; less than half the cumulative CPI. Even in VA expenditures for compensation and pension the increase is well below the cumulative CPI. Between 1975 and 1984 compensation and pension spending rose from $7.9 billion to $14.6 billion, only 85 percent. Given the clear restraint in VA spending over the last 10 years by contrast with the cost of spending on other programs, the VA budget has been a model of prudence; one not needing further restraint beyond what has already been built in.

CONCLUSION

Mr. Chairman and Members of the Committee, in this statement we have addressed a variety of subjects we consider to be of special importance to the nation's veterans that are included in the Budget Message of the Administration for the VA. We have spoken to those programs we believe to be of highest priority in an agency whose activities all are of high priority, because they are intended to respond to the needs, first of those who were disabled in war service, and then to the reasonable needs of all those who served honorably when called to do so by the nation.

Americans are a responsible people, and The American Legion is a responsible organization. We have not, and will not seek from the Government, more than we believe are the just dues of the men and women who have answered the call of the elected government, to defend the national interest in the Armed Forces. As has been stated to the Committee on other occasions, it is the position of The American Legion that when the national priorities are set, funding for veterans programs should rightfully rank second only to national defense, which must be the first national priority at all times.

We endeavor to leave the Committee with the understanding that The American Legion does not feel that the Administration's request for funding of all programs administered by the Veterans Administration is satisfactory. We have offered specific comment on those areas in which we feel funding is inadequate, and we have addressed each of the legislative initiatives with respect to the concerns of this organization. We trust the Committee will examine and consider the problem areas we have identified. As time and opportunity permit, we will be prepared and look forward to the opportunity for discussion and dialogue with the Committee about the various veterans programs the Committee will be considering during the present session.

Mr. Chairman, we appreciate this opportunity to present our views.

The American Legion

For God and Country

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February 27, 1985

Honorable G.V. (Sonny) Montgomery
Chairman
Committee on Veterans Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Montgomery:

This is in response to the question posed by Ranking Minority Member, Mr. John Paul Hammerschmidt, during the Hearing by the Committee on the proposed FY 1986 Veterans Administration Budget, February 21, 1985. Mr. Hammerschmidt asked us to provide for the record, the position of The American Legion, and actions taken by this Organization on the means test relating to eligibility for VA medical care for nonservice-connected veterans that was implemented in the 1950s.

The plan was first implemented in 1953 in the form of an addendum to VA Form 10-P-10. According to Circular No. 11, issued by then Administrator H.V. Higley on November 4, 1953, the addendum was designed to protect applicants for hospitalization, and veterans generally, from charges of "chiseling" on the government by signing a false statement of inability to defray the necessary expenses of hospital or domiciliary care.

From what we are able to ascertain, little, if any, serious attention was given to the new procedure. The Circular stated, in part, the following:

"Use of this addendum should cause each applicant for hospitalization to focus his attention on his financial status, and thereby give him clearer understanding of the propriety of signing the oath of inability to pay. To assist him in determining his ability to pay, the applicant should, if and when practically possible, be given some indication of the possible length of required treatment.

"This addendum may be used in no way whatever to deny hospitalization to a veteran as the law specifically provides that 'the statement under oath of the applicant . . . shall be accepted as sufficient evidence of inability to defray necessary expenses.'.

"If a veteran -applicant for hospitalization signs the oath of inability to pay contained in VA Form 10-P-10, that is legal evidence of eligibility for hospitalization and the applicant shall be admitted when a bed is available and the need for hospitalization has been medically determined."

The position of The American Legion at that time was that the new procedure should be given a reasonable trial. Therefore, the Legion did not oppose the use of the addendum to VA Form 10-P-10 under the stipulations set forth in Circular No.11.

It was not until January 1962 that VA proposed a rigorous admission procedure that was officially effective October 1, 1962. The initial proposal was very lengthy and complicated. Briefly, it included a formula to be applied to the applicant's ready assets which were to be matched against the net cost of private hospitalization. If the results of the application of this formula indicated that the veteran was able to defray the cost of hospitalization, the veteran was to be counseled by an Admission Counsellor. If tentatively eligible the veteran was to be examined by an admitting physician. If the veteran was in need of hospitalization for a nonservice-connected disability or illness, and was not in receipt of pension, an estimate of the probable length of stay in a community hospital was to be recorded. If surgery was anticipated, the contemplated surgical procedure was to be described. If a private physician had previously provided the foregoing information and the examining physician did not agree with the estimate, new estimates were to be recorded, etc., etc., etc..

The American Legion was strongly opposed to this procedure, and so advised The Administrator of Veterans Affairs in a letter dated March 28, 1962 protesting the use of such a stringent hospital admission policy. The Legion's opposition was not a knee-jerk reaction, but a well thought-out position based upon input elicited from Department Service Officers through the use of a questionnaire provided by this office, and a thorough staff analysis of the proposal.

During the National Convention of The American Legion October 9-11, 1962, the Delegates resoundingly approved Resolution No. 519, opposing the new VA hospital admission procedure. A copy of Resolution No. 519 is attached herewith. Briefly, it resolved that The American Legion protests the procedures to be instituted by the Veterans Administration as defined in Circular 10-62-130 of August 9, 1962, as unnecessary, impracticable, defective, and offensive, as well as objectionably harrassing to decent and self-respecting veterans applying for benefits to which they are entitled by law. The resolution further resolved that the National Organization of The American Legion seek withdrawl of Circular 10-62-130 by VA, and that it also rescind any instructions making such procedures operative; and finally, it resolved that, if the Veterans Administration will not comply with such petition, the National Organization of The American Legion seek relief by Federal legislation.

The approval of Resolution No. 519 officially established the policy of this Organization on the "means test" that was established by VA at that time.

Chairman Montgomery, The American Legion appreciates the interest of the Committee in the views expressed by The American Legion.

Sincerely,

John Sommer
JOHN F. SOMMER, JR.
Deputy Director
National Veterans Affairs and
Rehabiltation Commission

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attachment

FORTY-FOURTH ANNUAL NATIONAL CONVENTION OF THE AMERICAN LEGION
LAS VEGAS, NEVADA, OCTOBER 9-11, 1962

RESOLUTION: No. 519 (New Jersey)

COMMITTEE: Rehabilitation

SUBJECT: Veterans Administration Hospital Application Form

WHEREAS, under the provisions of Title 38, United States Code, Chapter 17, Subchapter II, Section 610 relating to Hospital or Domiciliary Care and Medical Treatment for War Veterans, "The Administrator within the limits of Veterans Administration facilities may furnish hospital care to a veteran if such veteran is unable to defray the expenses of necessary hospital care"; and

WHEREAS, Section 622, Title 38, United States Code, provides that "for the purpose of Section 610 (a) 1, Section 610 (b) 2, and Section 624 (c) of this Title, the statement under oath of an applicant on such form as may be prescribed by the Administrator shall be accepted as sufficient evidence of inability to defray necessary expenses;" and

WHEREAS, the Veterans Administration, the Bureau of the Budget, the staff of the House of Representatives Veterans Affairs Committee, each specifically and other governmental and private agencies incidentally, have repeatedly conducted surveys, inquiries and investigations seeking evidence of widespread and flagrant violations of law in the application for and the extending of hospital care for non-service connected conditions; and

WHEREAS, none of these frequent and repeated investigations has developed any material proof of "false swearing" or other violations of law on the part of veteran applicants for such hospital care; and

WHEREAS, in published official reports of governmental agencies relating to these investigations, with particular reference to "false swearing" and other violations of the law, it has been clearly and unmistakably shown that the evidence failed to substantiate abuses of such "false swearing" or other violation of the law but, on the contrary, responsible authorities of the governmental agencies have stated such abuses were found to be "negligible" or less than one percent, thereby attesting to highly efficient and effective administration of the law; and

WHEREAS, the Veterans Administration, despite the conclusive results of all inquiries as above described, has published Circular 10-62-130 dated August 9, 1962, indicating that new procedures under the provision of said Circular are to become effective October 1, 1962; and

WHEREAS, a study of these new procedures clearly indicates that they ignore valued experience in determining eligibility for non-service connected hospital care and substitute therefore a highly theoretical concept devoid of any fair and equitable treatment of applicants or, more particularly, application of sympathetic understanding and good judgment in appraising lividual cases; and

WHEREAS, since the law defines the basis of rendering non-service connected hospital care in simple and positive terms, a serious question arises as to whether the Veterans Administration can negate the will of the Congress by instituting prohibitive regulations to dissuade applicants from seeking non-service connected hospital care; and

WHEREAS, the new proposed procedures have the effect of threats, intimidation and power tactics to be applied to the applicant not only at the Regional Office level but duplicated and repeated at the hospital at time of appearance for admission (threat and "intimidation" is definitely implied in the processing procedures in the review and re-review of the applicant's statements, with frequent reference to "impressing the veteran with an understanding" of statements made, to the significance of his oath, and the penalty of "false swearing" (see Item 4, Processing Procedures, paragraph h), and that any suspected violation will be "referred to Central Office" (Item 1, paragraph c) - such frequent and pointed statements can only be interpreted as power tactics "intended to frighten and to terrorize a sick veteran with the power of the Federal Government as a prosecutor); and

WHEREAS, a further study of the new procedures develops a concept that the Veterans Administration is now to become a sales agency for private hospitals in the communities throughout the country (no other logical conclusion can be rationalized from the very great stress and emphasis in estimating community hospital costs, and in "counselling" the veterans as to its availability); and

WHEREAS, still further study of the new procedures reveals a very definite tone and tenor implying that applicants for non-service connected hospital care should be received with suspicion and regarded as potential chiselers (the specific instruction to counsellors to inquire deeply not only into a veteran's private affairs, but to seek motivations in the fact that application is made for such care - the whole attitude designed for counsellors by these new procedures is offensive, insulting and degrading to decent veterans legally applying for a benefit available to them under the law); now, therefore, be it

RESOLVED, by the 44th Annual National Convention of The American Legion, assembled in Las Vegas, Nevada, October 9-11, 1962, that it protests the procedures to be instituted by the Veterans Administration as defined in Circular 10-62-130 of August 9, 1962, as unnecessary, impracticable, defective, and offensive, as well as objectionably harassing to decent and self-respecting veterans applying for a benefit to which they are entitled by law; and, be it further

RESOLVED, that the national organization of The American Legion seek withdrawal of Circular 10-62-130 of August 9, 1962, by the Veterans Administration, and that it also rescind any instructions making such procedures operative; and, be it further

RESOLVED, that, if the Veterans Administration will not comply with such petition, the national organization of The American Legion seek relief by federal legislation.

PVA

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING THE

PROPOSED FISCAL YEAR 1986 VETERANS ADMINISTRATION BUDGET

FEBRUARY 21, 1985

Mr. Chairman and Members of the Committee, it is a privilege for me to speak here today on behalf of the members of Paralyzed Veterans of America.

Initially, Mr. Chairman, I want to take this opportunity to officially welcome the new members of the House Committee on Veterans' Affairs. PVA looks forward to working with them, the other members, and you, Mr. Chairman, and the fine staff of the Committee on Veterans' Affairs. As this Committee begins its work in the 99th Congress, PVA believes that with all of us working together we can and will address and improve the VA programs that provide for our Nation's veterans and their dependents.

I sincerely appreciate this opportunity for PVA to address its views and concerns regarding the Administration's proposed Fiscal Year 1986 VA Budget.

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PVA recognizes the need to reduce the federal deficit, but in examining the proposed Fiscal Year 1986 VA Budget, we find the targeting of veterans' health care and services as a source of spending cuts and deficit reduction to be a reprehensible approach and a disservice to the men and women who have served the nation.

Historically, this country has cared for its veterans. This huge task cannot be left to state and local governments which are not equipped for such an effort, and are already overburdened. The cost for providing for our nation's veterans is an obligation that is associated with the continuing cost of our national defense.

Mr. Chairman, this year, the nation's 28 million veterans, and their 53 million dependents and survivors will have to rely upon the wisdom and energies of this Committee, and Congress as a whole, to secure adequate funding for the programs and services administered by the VA. Repeatedly, the Congress has had to struggle to add funding to proposed budgets that were patently insufficient to meet the needs of the nation's veterans, and the task this year will certainly be as challenging as any we have witnessed during the past several years.

The Administration's proposed budget falls short of meeting the current needs of veterans and fails to adequately address future needs. The proposed budget authority of $27.1 billion is a decrease of $123.5 million from the current, fiscal year 1985, level. And, the proposed budget fails to provide for the needed growth of facilities and services that was so clearly projected only twelve months ago. Last year before this Committee we were able to state:

> "The proposed 1985 budget authority of $27.2 billion, if accepted by Congress, will generally preclude the diminution of VA programs. And, the proposal in certain instances, such as funding for medical care and construction of nursing homes, represents a real attempt to improve existing VA services and redress past neglect."

It is obvious that the Administration's commitment to providing adequately for the nation's veterans has been short lived. The proposed Fiscal Year 1986 budget not only reduces the progress achieved in the last year, it portends even greater damage to veterans' programs and services in future years. This year's budget proposal does not even stay abreast of inflation and even more detrimentally it proposes a reduction in excess of $100 million. This, coupled with the ever increasing demand being placed on the VA system by the aging veteran population can only result in the reduction and decline in the quality and quantity of services to veterans.

During the course of our examination of the Administration's proposed Fiscal Year 1986 Veterans Administration budget it has become clearly evident that economic concerns have far outweighed moral obligations. The proposed budget fails to address veterans needs, now and in the future, and indicates a trend of abrogating what has historically been the nation's responsibility toward the men and women who have served in its defense.

The Administration, through its FY'86 budget proposal, makes quite clear its imperviousness to any understanding of the medical needs of the aging American, let alone the aging veteran. The coming impact of the aging veteran had been a responsibility which the Veterans Administration was taking very seriously. After more than a year of demographic analysis, discussion and review by outside consultants, it published in mid-1984 a comprehensive report "Caring for the Aging Veteran." The veracity of this report was further supported by a Lou Harris survey and contracted studies by Harvard University's Division of Health Policy Research and Education. A simultaneous report from the Congressional Budget Office concurred with the data obtained from the VA's demographic survey.

The VA plan provided a detailed overview, based on projected need, of the opportunities presented by the aging of its constituents. Where as three million veterans today are over age 65, by the year 2000 that number will triple to nine million or 36 percent of all veterans. Because it is dealing with a population whose average age is increasing much faster than that of the general population, the VA's accommodation to this impact could serve as a proving ground for private sector programs to follow.

To maintain current levels of care the nation's elderly will, by the year 2000, occupy all of today's empty hospital beds and require a fifty percent increase in present nursing home facilities. In more dramatic terms tomorrow's elderly will require the opening of one hundred nursing home beds every day for the next fifteen years. Today the VA alone supports an average census of twenty five thousand veterans in nursing homes, sixty percent of whom are in community nursing homes. This need will double by 1995.

The main emphasis in expanding VA geriatric capability, however, was to be placed on non-institutional care programs such as outreach satellite clinics, adult day care centers and rehabilitation units, hospital based home care and hospices. The VA had intended to seek legislation in this area for increased sharing and coordination with the private sector. The goal was to exert maximum effort to integrate VA programs for the elderly with similar programs in the community at large.

In spite of these well documented requirements no program enhancement resources appear in the proposed coming year budget or in its out year projections. In contrast, OMB budget guidance contains the words "shrink the VA system size gradually." Blocking the development of geriatric program alternatives to institutionalized care will have a stultifying effect on the VA's system, and will itself add to overall costs and, in turn, drastically retard the nation's preparedness to meet the medical and socioeconomic needs of its aging citizens.

FY'86 budget cuts affecting the private sector are also of significance to veterans because of the impact upon the VA health care-system. During the past few years Congress has reduced projected Medicare/Medicaid expenditures by some 18 billion dollars. The President has proposed additional cuts from Medicare and Medicaid of $5.9 billion in FY'86 and $27.1 billion by FY'88. Included are reductions in Medicare reimbursement for capital expenditures; a fifty percent reduction in Medicare indirect subsidy for medical residency education and severe cuts in federal support for medical education loans and scholarships.

The fact and future of the VA and the private sector medical systems are inextricably linked. One third of all veterans over the age of sixty-five are said to be medically indigent, which may explain why the VA medical system is proving to be a demonstrable safety net for veterans who can no longer afford the increased co-payments of Medicare. In 1983 some 800,000 of the three million veterans over age sixty-five came to the VA for one form of care or another. That represents over twenty-five percent of all veterans in that age group. And one half of them had never previously made use of the VA health care system.

FY'86 budget decrements for the VA Department of Medicine and Surgery are, in many ways, reflective of options under continued study by the White House Office of Policy and Planning. These options have been identified in the recent Congressional Budget Office report on "VA Health: Planning for Future Years," the notoriously flawed Grace Commission Report, and by the Office of Management and Budget itself.

It is unlikely that the VA health care system could be dismantled by fiat, but there is clear and present danger that full implementation of certain of these options would be tantamount to its destruction. Unfortunately, the purpose, the nature and the value of the system as a national resource is little known and even less understood by the public. Only with such understanding can the impact of certain policy proposals targeting veterans medical care be measured.

The VA Department of Medicine and Surgery is the nation's largest integrated comprehensive system. It is the only system providing a full continuum of health care to veterans made eligible for care on the basis of laws passed by Congress and signed by the President. From its research laboratories have come tremendous contributions to medical knowledge. The VA is also the nation's single largest health manpower production resource and, as a key element in national security, the principal on-line contingency backup to military medicine. It is a system clearly worth saving. It is, in fact, a model for the nation, a harbinger of things to come. Its integrated, comprehensive provision of service is a blue-print for the vertical and horizontal integration now underway in the private sector's effort to adjust to the competitive medical market.

Up front should be an appreciation that the VA has an exemplary record in cost containment. There has been no growth in terms of inflation corrected constant dollars in its annual medical care budget for the past ten years. During this time the annual inflation rate for the Medical Care Price Index averaged twelve percent while the yearly VA medical operating costs increased by seven percent. The FY'75 VA medical care budget figure was $3.7 billion and in FY'85 $3.6 billion in constant 1975 dollars.

During this decade of straight line budgeting there was, however, a marked increase in productivity and economy. The average length of patient stay was reduced by one-third and the total annual patient work load increased by thirty percent. Annual out patient visits increased by two million. An additional 3,723 nursing home beds and sixteen out patient clinics were added to the system and 136 new Vet Centers provided readjustment counseling to over 300,000 Vietnam Era veterans. During the same period sixteen thousand VA hospital beds were closed.

In light of the progress made in the VA health-care system in terms of efficiency and the increasing demand being placed upon it, it is most disturbing to PVA that the Fiscal Year 1986 budget proposal contains provisions which can only be detrimental to the VA and the veterans it serves. The proposed funding for medical care is decreased in constant dollars and the proposed medical construction budget is reduced substantially from the current level. Specifically, the reduction in FTEE's and the proposed five percent pay reduction will have deleterious effects on veterans. In addition the cost saving initiatives contained in the budget proposal are questionable at best.

Of critical concern to PVA are the staffing levels proposed for the Department of Medicine and Surgery and the simultaneous treatment of that staff. The proposed budget not only denies the need for increased staffing to meet the rising demand but also carries over current inadequacies by "freezing" DM&S employment levels at Fiscal Year 1985 levels.

During Fiscal Year 1986 the VA is scheduled to activate, or open a number of facilities, such as new nursing home care units, outpatient clinics, renovated hospital wings, and outpatient clinic additions, which will require over 2,000 new employees to staff these facilities. The proposed VA budget fails to make funding available to meet these increased staffing requirements. Instead, the budget presumes that productivity increases will offset the need for this increased staffing.

By disregarding the clear, congressionally intended staffing levels for Fiscal Year 1985, by over 2,000 FTEE's (which is carried over into the 1986 budget), and the failure to provide the VA with the 2000-plus FTEE's needed to staff newly constructed facilities, the proposed budget results in the Department of Medicine and Surgery being 4000-plus employees below the number needed. It goes without saying that it makes no allowance whatever for the inevitable escalation in demand for services associated with the increasing number of older veterans who are now eligible for and requesting health care from the Veterans Administration.

PVA is also very concerned over the wisdom of the Administration asking all government workers (including VA employees) to submit to a 5 percent pay cut this October 1. It is within the purview of "Uncle Sam," as an employer to request this of his workers, but the request must be questioned especially if increased productivity, good employee morale, and retention of a good labor force is desired.

Based upon an independent study which was just completed and transmitted to the House Committee on Post Office and Civil Service on December 4, 1984, (Hay/Huggins study) today's Federal worker is already underpaid. In fact, if comparing cash compensation only, the study shows that General Schedule (GS) worker's pay would have to be increased by 10.3 percent just to match private sector pay levels for equivalent positions, and the differential for a given GS position range from 2 percent, at the lower GS grades to 25 percent in the upper grade levels.

Given the benefit of Federal civil service retirement system part of this difference is lost. Still when comparing total compensation paid (wages, health and disability benefits, retirement, vacation, etc.) the Federal employee lags behind his private sector counterpart an average of 7.2 percent. Taking into account the changes being proposed for the Federal worker's retirement program and this 5 percent pay cut, the differential between Federal and non-Federal work compensation will become even more exacerbated.

The question must be asked, "Can we afford the long-term consequences that this 5 percent pay cut can have on the efficiency and productivity of the Federal work force."

PVA is adamantly opposed to any such pay reduction because we know firsthand the devastating effect it portends for a system that is already understaffed, especially as it exists in many spinal cord injury units and rehabilitation facilities. The ability to attract, to train, and to maintain qualified personnel to carry out the Federal responsibilities mandated by Congress is largely dependent upon that employer being equitable both in the treatment of their employees and the rate of compensation paid them.

The VA's FY'86 proposed construction budget of $611.6 million in new budget authority indicates that the Administration is not recognizing the importance of maintaining and building adequate facilities, if the VA is to perform its assigned functions. This is particularly true regarding the emphasis on the construction of new nursing home facilities.

It had been previously determined that just to replace the system's antiquated hospitals and maintain its plant facilities at the current size would require a one billion dollar (in constant 1985 dollars) construction budget for the next ten years. Implication of intended future policy is also to be found in the FY'86 guidance that construction projects in the out year should be sized solely upon service-connected demographic need. This is consistent with the Administration's limitation of nursing home construction to two 120 bed facilities in FY'86, a reduction of 720 beds from the level requested.

The needs of the aging veteran population will continue to place ever-growing demands on the VA's health-care delivery system, and it is extremely important that adequate physical facilities be developed and maintained to meet this demand.

Mr. Chairman, the construction proposal is not a positive sign, and it raises several questions. The failure to construct needed VA medical and health-care facilities has been one of the most troublesome veterans' issues for quite some time: by "construction" PVA means both the building of needed new facilities and the maintaining of existing ones. It is a very serious matter that so many VA facilities are now in a state of decay, after a grateful nation has provided them. Some are only marginally meeting the needs of the veterans who use them. Decaying facilities not only hamper patient usage of some VA medical facilities, but their poor condition makes it doubly difficult to recruit and retain qualified staff.

Mr. Chairman, PVA must also question the cost savings initiatives contained in the Fiscal Year 1986 budget proposal. The implementation of a "means test" assumes that veteran demand can be reduced and the establishment of third party reimbursement is anticipated to produce $65 million in savings.

We are skeptical not only of the projected savings but doubt that such programs will mitigate the growing demand being placed on the VA health-care system.

First, PVA does not oppose a "means test" per se. The institution of any "means test," however, must be equitable, being applied to all non service-connected veterans regardless of age and it must address factors other than gross household income. Significant factors such as the totality of a veteran's health-care needs must be considered in making eligibility determinations rather than relying on a single episode determination. Additionally, the factor of geographic differentials in living costs must be incorporated into any "means test". The establishment of criteria for determining what is household income poses a significant problem.

Most important, the use of a preliminary medical evaluation should not be used as the controlling factor in determining a veteran's health-care needs and ability to pay. A complete, comprehensive diagnosis, post-admittance if necessary, and a thorough consideration of future medical requirements must be incorporated into any determination of ability to pay. If an admitted, diagnosed veteran is then deemed to be able to defray costs, a mechanism for recoupment of diagnostic expenses should be considered whether third party reimbursement or not.

Finally, the question of cost effectiveness must be raised. The institution, nationwide, of the proposed means test implies significant administrative costs with no assurances that the VA will realize savings. If the means test were to winnow out certain veterans with the ability to pay, others currently being denied care would only be admitted to the system. While such a result is a positive aspect of the proposed means test, it can in no way be viewed as a means of reducing costs or demands on the system. Additionally, any use of a preliminary evaluation will address only individual episodes of health-care need and fail to consider the veteran's more extensive spectrum of medical requirements.

The proposal to effect cost savings of $65 million during fiscal year 1986 through the establishment of third party reimbursement is specious at best. Non service-connected veterans utilizing the VA health-care system do so today because they lack the resources to secure private health care. These veterans, for the most part, have no private health-care coverage. In the cases of those veterans who do have private coverage most extant policies contain exclusionary provisions which preclude payment for treatment in federal facilities.

In addition, the administrative mechanism to implement third party reimbursement currently does not exist within the Veterans Administration. The projected savings assumed in the budget would have to be the net result of establishing such a program and its associated costs. Additional FTEE would be required to administer such a program and a billing procedure would have to be created.

Mr. Chairman, PVA must also address the implications of this budget for the Department of Veterans Benefits. The proposed Fiscal Year 1986 Budget contains a total VA personnel reduction of 919 FTEE's, with the major portion thereof consisting of 624 in DVB alone. As of current date, DVB has not furnished a firm, detailed plan for implementation of the proposed budgetary personnel reductions. The essence of the plan is a consolidation of all adjudication, loan processing, finance, administrative and personnel functions now individually conducted in the various regional offices and centers into three regional centers located in the eastern, central, and western United States.

An appropriation of $25,000,000 is to be allocated for the cost of consolidation. We are challenging this estimate as grossly inadequate, considering costs such as what we consider to be a realistic estimate of $35,000 to $40,000 alone, as a relocation cost per individual. Our challenge is also based on consideration of costs of finding and leasing, buying or building, suitable quarters for the consolidated offices; overlapping leases and costs of breaking leases; packing, shipping and relocation of files and equipment; installation costs of telephonic and other communications equipment; direct and indirect employee costs such as severance pay, early retirement and inevitable loss of production and deterioration of employee morale as office closings and relocations become imminent. Another major factor will be the cost of procuring, installing and programming computers with adequate capacity and training operators for such equipment.

Bearing on the logistics of consolidating all active claims folders in three centralized locations, consideration will have to be given to the sheer immensity of the files storage problem. Based upon representative inventory figures obtained from what we consider an average sized Adjudication Division, we have made the following assumptions and computations. Of the approximate 105,000 C-Files in that office, 90,000 are considered active.

They are housed in filing cabinets which are fifteen inches wide and approximately twenty-five inches deep. These 5-drawer cabinets have an average of 40 files per drawer or 200 per cabinet. We have conservatively extrapolated a total of 5,220,000 active files in the United States based on multiplication of 90,000 by 58 RO's.

Dividing this total number of active files by 200 gives us a requirement of 26,100 cabinets which, taking a total of 1.25 linear feet (width) each, comes to 32,625 linear feet or a national total of six miles of cabinets or two miles of cabinets per consolidated office. In terms of area, these cabinets require 5.2 square feet each (including a 25 inch aisle) or a total of 135,720 square feet or approximately 45,000 square feet of space for the cabinets alone in each consolidated office. Add to this the square footage of the requirements for cross aisles and working space for the employees, their necessary equipment, and adjunct facilities.

The sheer immensity and volume of folders per regional office, conservatively at least 1.75 million files per office, further presents the question of the time factors which must be considered for obtaining any given file. Of much more serious consequence is the ever-present danger of a major loss of C-Files, with all of their irreplaceable military and personal records, correspondence, etc., in the case of a catastrophic fire, comparable to the disaster at St. Louis in the early seventies when many millions of irreplaceable veterans' records were destroyed. Many a veteran undoubtedly suffered a denial of his claim, solely due to the fire.

The proposed consolidation will produce both tangible and intangible consequences. From management point of view they anticipate a cost saving after the initial cost of moving and consolidating is hurdled. However, we perceive damaging costs and consequences far exceeding in scope and importance any monetary benefit gained by the consolidation. In the VA publication entitled "Budget in Brief Fiscal Year 1986", the VA includes a preamble entitled "MISSION & GOALS". The VA states that its mission includes an obligation to be the "principal advocate" of veterans and their families in ensuring that they receive the benefits they have earned in service to this Nation. Further, the VA strives to ensure that an appropriate level of benefits is provided within the law to eligible veterans and beneficiaries. We are greatly concerned that the VA will be straying far from its "mission" and that consolidation will result in and produce a major deterioration through the depersonalization of claims processing.

The removal of processing employees from the respective areas they currently serve has the inevitable consequence of divorcing them from any sense of local identity and responsibility. There will be the loss of the ongoing relationship carefully cultivated in office after office by the top management, including the Adjudication Officer and his staff as well as by the Director's office with local facilities, agencies and important officials. This local friendly relationship and knowledge of local agencies such as police officials, courthouse personnel, and local record keeping agencies often proves vital in cutting red tape and expediting processing of claims.

We perceive an immediate increase in the piecemeal assembly of data required for claims processing, with a consequent increase in the time required for effective development of claims. An immediate sequel to poorly developed and poorly adjudicated claims is a corresponding increase in the filing of appeals by dissatisfied claimants. The more the VA will have to rely on computer-generated correspondence, the less detailed and explanatory will be their letters. Consequently, the level of dissatisfaction referred to above will inevitably increase the already heavy BVA load, significantly increasing its backlog and lengthening appeals processing time.

A major loss to the entire veterans' community throughout this Nation will be the deprivation of an availability of a local office at which a veteran or other claimant could appear for a personal hearing. Long experience tells us that a hearing is most effective when conducted before the very people who will be making the decision. Even if the VA were to provide alternative methods of conducting hearings by a separate hearing body in local areas, we submit that with the claims folders located in only three areas, the final decision will most probably be made by rating personnel who have had no contact or feel for the individual in question.

But the greatest concern we have relates to the impact any consolidation would have on the existing role of National Service Officers, of this organization and of all others, now located in every regional office, where they are geared to providing personal one-on-one service with claimants. In turn, these service officers have all developed effective working relationships with their respective VA Adjudication personnel. Both the VA and the claimants have thus benefitted from this relationship. We cannot perceive how such an effective one-on-one relationship can be replaced or duplicated at the three consolidated offices. The quality, effectiveness, and timeliness of all services to claimants, promised so openly by the VA, can only deteriorate under the proposed plan.

In essence, the service organization representatives will be neutralized without local access to the VA C-files. With no case development at a local level, the time to process these claims will double, if not triple, because of the time factor involved to collect pertinent information.

The 1986 budget will indeed cause a severe hardship as far as staffing problems, cost of relocation and forced restructuring of the service organization's work force in the field. Service organizations would be forced to beef up their development staff in the consolidated regional offices and, therefore, would be faced with the costs related to relocating their own personnel. Furthermore, the relocations made would cause a serious reduction of the work force which would otherwise be available to staff the remaining service organization contact offices in the field.

Also taking into consideration the relocation, as well as the loss in work force, we feel it imperative that the VA consider the loss of the free assistance afforded them by the veterans' service organizations. For example, the combined veterans' organizations last year alone handled approximately 35% of all claims filed and 40,000 personal hearings, both formal and informal. Relative to the hearing processes, the veterans may be subjected to traveling great distances and be expected to defer the expense of their travel and lodging out of their own pockets, if they desire to expedite their claims and not wait for the travelling board. Furthermore, there will be the more severely disabled veterans with the same desires who would be deprived of this right because of their physical inabilities to travel the great distances which could be involved. In any case, the loss of one on one personal contact with the veteran and his representative will be limited, if not totally destroyed, in untold thousands of cases.

Taking into account the ramifications of this budget's effect on the service organizations, also raises questions as to the VA's ability to handle the projected workload, when considering the consolidation and resultant reduction in personnel to include the assistance afforded by service organization representatives. There will be an overall impact on a number of the smaller organizations due to their limited availability of funds that must be considered. They would not, in fact, be able to afford to defray the expense of transferring service officers into the three designated regional offices and, therefore, the ability to represent their clientele would be severely hampered if not actually obviated.

The extended claims processing time is a priority issue as viewed by the service organizations. It is our opinion that we could safely project a 50 percent increase in the time involved to process a claim from the date filed to the date the veteran is notified of the decision. This extended processing time will add to the severe hardship which is placed upon those veterans awaiting a decision from the Veterans Administration and who are indeed in desperate need of this assistance. We further anticipate the sheer volume of the caseload anticipated and resulting confusion of a consolidated operation can be expected to increase, and cause disruptions of the flow of vital information necessary to prosecute pending claims. In view of the present economic state, literally thousands of veterans are being forced to turn to the VA for assistance for the first time in their lives. If one also takes into account the present age of the World War II veterans as well as the Korean veterans and the increase of Vietnam veterans now seeking benefits from the Veterans Administration, we find it difficult to accept the VA's projections of a reduced workload in the upcoming years.

In summary, indications are that the proposed DVB budget cut was made arbitrarily, and the proposed consolidation of regional offices into three locations was made in desperation, on orders to cut costs, rather than by plan. As a result, there is no evidence of a firm plan for the targeted reduction of FTEE projected during the next three years, or in fact, even where the cuts are to be made. Additionally, the tentative locations of the consolidated claims centers have not been identified, or feasibility studies conducted.

Taking into consideration our conservative estimated space requirements for each site, it is difficult to visualize how the VA can realistically select a site, without making a detailed space requirement analysis, and then secure an adequate sized building in the selected location (if one exists) before the proposed FTEE reductions are actually made. Obviously, if the proposed reductions become fact before the preliminary plans and related arrangements are completed, the actual damage to the ability of the VA to process claims accurately and in a timely manner cannot be estimated. We may experience chaos in the system that will take many years to rectify, not only in regard to the disrupted administrative procedures, but more importantly, the irrevocable damage done to the well being of the needy veteran dependent on VA benefits services for survival.

Another issue of concern to the members of PVA is a proposal within the VA's "Home Loan Guaranty" program. This is an entitlement program, with every veteran meeting the requirements, as provided by statute, being eligible for the guaranty of their mortgage. Since its inception in June 1944, the VA Home Loan Guaranty Program has assisted over 11 million veterans and their families in gaining suitable, affordable housing.

The Guaranty can be made up to 60 percent of the loan or $27,500, whichever is less. In the event of default, the VA will pay to the lender the outstanding balance due on the loan plus costs incurred through foreclosure, up to the amount of the guaranty. In most cases arrangements have been made for the lender to convey the property to the VA, in order to encourage lender participation in the VA Home Loan Guaranty Program, to minimize administrative costs, and, most importantly, to retain flexibility to allow a deserving veteran in the family home even after mortgage default.

Now this year, the Administration is proposing legislation to increase funding fees on VA guaranteed loans from one percent to five percent. Veterans who use their VA Guaranty entitlement, and purchasers of VA owned property would either have to pay the five percent fee up front, or pay a one percent fee while making a minimal down payment of five percent, or have the five percent added into the loan, thereby raising the actual amount borrowed, coupled with having Private Mortgage Insurance added to the monthly mortgage payment.

Putting this added cost into the VA Home Loan Guaranty program would all but insure the demise of the program and of veterans being able to use their VA entitlement in obtaining affordable housing.

The average cost today of a VA guaranteed home is $60,000. By adding the new five percent funding fee, veterans would require at least $3,000 cash just to be eligible to use their VA guarantee for housing.

One of the most valuable benefits in the VA Home Loan Guaranty Program has been the feature of no money down. A veteran may now buy a home with no down payment, providing his or her income is sufficient to support payments; the VA's home loan program is the only home lending program that carries this feature.

Another aspect of the housing proposals is to repeal the current authority to establish maximum interest rates and allow for borrower/lender negotiated rates. Currently, under Title 38 the Administrator has the authority to set maximum allowable interest rates. The FHA in 1983 repealed their interest rate policy similar to the VA's current policy, choosing instead to go to a negotiable rate.

Introduced in the 99th Congress, as H.R. 1 (Section 533), is legislation that appeals the current authority by FHA, and reverts back to current policy being used by the VA. This alone should be an indication that the proposed method of negotiable rates by borrower/lender does not work. PVA opposes the proposal of raising the user fee from one percent to five percent and repealing the authority for setting the percent rates. We believe that the current VA Home Loan Guaranty program has and continues to serve veterans well, giving the veteran borrower the opportunity to secure a low cost loan, with no down payment, thereby fulfilling the American dream of owning a home.

And finally, Mr. Chairman, ending on a positive note, the proposed Fiscal Year 1986 VA Budget contains a 4.1 percent increase in the rates of veterans receiving disability compensation, Dependency and Indemnity Compensation, and nonservice-connected veterans and widows in receipt of pension, effective January 1, 1986. PVA welcomes this proposal because we continue to believe that veterans and their survivors must not be subjected to the erosive effects of inflation.

It must be noted, however, that there continues to be consideration given by certain members of the Administration and others to the possibility of taxing compensation and other veterans' benefits. PVA finds such suggestions abhorrent. Compensation is provided to veterans for injuries or conditions sustained in or aggravated by service to the nation. It is unconscionable to give legitimacy to any of these proposals.

In closing, Mr. Chairman, it is PVA's belief that there are areas within the Veterans Administration which, if properly addressed, can be made more cost effective and efficient. It is recommended that this Committee, and Congress as a whole, require the Agency to submit a comprehensive Automated Data Processing (ADP) initiative to the Congress prior to the submission of the Fiscal Year 1987 budget. The VA's ADP system is plagued with problems and current, piecemeal efforts offer no prospect for successful resolution. The present method of requiring $1.10 reduction in FTEE expenditures for every

$1.00 spent in ADP acquisition is an impractical and illusory effort to effect savings and enhance productivity.

Similarly, PVA recommends that the VA be tasked with providing a report to Congress before the next budget submission that establishes a bed sizing model which addresses the future needs of all veterans. This model must be applied consistently for new construction, as well as, conversion or closure of existing facilities. The reliance on the use of DRG's is inappropriate for such a model due to their newness and their failure to cover a significant number of conditions or multiple conditions being treated by the VA today.

Mr. Chairman, PVA is aware that this is a time of challenge. We recognize that it is incumbent upon all of us to insure that the taxpayers' money is expended in the most equitable and efficacious manner possible.

PVA believes it is a time of challenge for the Congress to provide leadership. We understand you face the adversity of limited resources. But remember, that the benefits and programs we are addressing today were earned in adversity. Integrity, honesty and constancy of both individuals and nations are, and always have been, tested in times of adversity, not times of plenty and of ease. The problems confronting us are a challenge to all of us and yet it is essential that we pass the test.

Mr. Chairman, and members of the Committee, I again thank you for the privilege of appearing today. I have discussed numerous concerns within the proposed FY86 VA's budget, but I hope I have lent some insightfulness here today. This concludes my statement, and I will be glad to answer any questions that I can.

THE NON COMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA

"STRENGTH IN UNITY"

Statement of

Richard W. Johnson, Jr
Director of Legislative Affairs

before the

Committee on Veterans Affairs
U. S. House of Representatives

on the

Veterans Administration Budget Proposal

February 21, 1985

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The Non Commissioned Officers Association of the USA, representing more than 250,000 associated members from all components of our nation's armed forces, is grateful for this opportunity to present its views on the Veterans Administration budget request for Fiscal Year 1986.

OVERVIEW

After months of speculation over its contents, the Veterans Administration budget request for fiscal year 1986 is now official. To the surprise of many it proposes a 4.1 percent increase in disability compensation and survivor benefit payments. However, beyond that commendable provision, the request grows more dismal.

Altogether the VA has requested obligational authority of $27.1 billion and outlay authority of $26.7 billion for FY 1986. These figures are down by $123 million in obligational authority and $82 million in outlays from FY 1985; a reduction of about one half of one percent. At the same time, inflation is expected to erode the value of the dollar by about 4 percent. In real terms, therefore, the VA budget request represents about a 4.5 percent real decrease in spending for fiscal year 1986. Acceptance of such a proposal can only result in substantially reduced services to veterans.

Rather than identifying program cuts, the VA has identified areas of "savings" which will reduce outlays in the next fiscal year. Many of these savings do not require Congressional approval such as the proposed consolidation of regional office functions and the application of a "means test" to veterans with non service connected disabilities who seek VA medical care. Other savings rely on Congressional approval of several very controversial programs such as increasing the VA home loan guaranty origination fee from 1 percent to 5 percent and reducing federal pay by five percent. In this regard, the budget proposal is highly speculative.

Overall, the budget anticipates that increases in the loan guaranty origination fee will offset the cost of living increases in compensation programs. At the same time, the proposal envisions that federal personnel pay cuts combined with the consolidation of regional office functions and reductions in other programs will provide the additional "savings" necessary to achieve the budget goals. To NCOA, both premises are undesirable.

DEPARTMENT OF VETERANS BENEFITS

As noted, several changes are proposed in veterans benefit programs for FY 1986. Most notable and laudable is the proposed increase in veterans disability compensation benefits and survivor benefits. If enacted as requested, this proposal will give veterans and their survivors a cost-of-living increase in an amount similar to the anticipated increase in indexed programs such as social security.

NCOA strongly supports this provision. However, the Association strongly objects to the concept of financing increases in one veterans program through assessments in another.

In this case NCOA is deeply concerned with and opposed to the proposed changes in the Veterans Home Loan Guaranty program. According to the VA proposal, the loan origination fee should be increased from one percent of the loan value to five percent of the loan amount. In somewhat smaller print, the VA has also suggested that the VA loan rate should be negotiated between veterans and lenders instead of fixed by VA regulation. The administration has estimated this proposal would save $404.6 million in outlays during FY 1986 without having substantial, adverse impact on participation in the program.

NCOA believes such action would totally destroy the program. Veterans will recognize that they are being asked to pay an average $3,000 fee which could be avoided or stretched out by purchasing private mortgage insurance on conventional loans. Veterans seeking no-down-payment loans will be put in the position of trying to borrow more than the property is worth. Even if the veteran is successful in finding financing under these circumstances, it is unlikely that such loans would be salable in the secondary mortgage market. These are just a few of the reasons such a proposal seems ill-conceived.

Last year, in response to an equally disconcerting legislative proposal, Congress reassessed the loan guaranty program. Some changes were made to insure the program was being managed properly and to preserve solvency in the Loan Guaranty Revolving Fund. Congress perceived the program to be beneficial to both veterans and government in that it assists veterans in home purchases while increasing the Nation's tax base and productivity. Throughout its existence this benefit has been provided to veterans at an average cost of less than $100 per participant. NCOA sees no reason to modify the program now.

Accordingly, NCOA recommends funding for the preservation of this benefit be included in the Committee's budget request.

A second area of abiding concern to NCOA in the budget proposal concerns the proposed consolidation of certain regional office functions into three centralized locations. Notwithstanding, the "start-up" cost requested in the budget, there is no disputing that this program would be a long term money-saver if allowed to go forward. Yet, if the VA is allowed to make such a consolidation, it will significantly denigrate the services provided to veterans. Indeed, the VA has indicated it does not intend to modify its regional office distribution to accomplish this consolidation. But, if they remove the functions they propose from those regional offices, they might as well keep 58 empty buildings with literature stands and mail boxes out front.

The regional office concept was designed to provide veterans ready access to claims adjudication and benefit assistance. This concept goes far beyond having benefit counsellors available to advise on programs and assist in the preparation of forms. It allows veterans personal access to those federal employees who will make decisions that will substantially effect their future and, at the same time makes it difficult for adjudicators and others involved to become so far removed from the public that cases are treated with callous disregard.

If the VA is allowed to carry-out this planned consolidation, timely consideration of claims for all benefits will suffer. Counsellors will not have ready access to records or personnel responsible for claims processing. It will become impossible for local VA representatives to answer even the most simple questions without making a long distance telephone call or writing a letter. The ability to "walk-through" paperwork of timely importance will be removed.

This program so modifies the scope of services provided by the VA that its impact should not be measured in dollars or savings. Instead it should be considered for its impact on effectiveness in meeting the VA's mission. NCOA suggests the committee not include the start-up money requested by the VA in its budget request. Additionally, the Association recommends the committee consider and adopt legislation to permanently foreclose on the possibility of future consolidation of regional office functions.

Notably missing from the VA budget is a proposal to increase Servicemen's Group Life Insurance (SGLI) coverage to a level which more reasonably meets the economic needs of people serving in the armed forces. At various times in recent years, this issue has been a priority to the Veterans Affairs Committees, the Department of Defense, and the Veterans Administration. It has certainly been a priority for the Non Commissioned Officers Association. However, procedural problems, minor disagreements between House and Senate legislation, and occasional objections by the administration to some proposals have led to recurring delays in adoption of an increase. Since the program is premium based, it will have almost negligible impact on the budget request. Nevertheless, NCOA recommends that such funds as are necessary to implement an increase in SGLI coverage be included in the committee's request.

DEPARTMENT OF MEDICINE AND SURGERY

Among the major proposals affecting the VA's Department of Medicine and Surgery are measures to substantially reduce construction, research, operating beds and personnel. The effects of some of these proposals are spread over several years. There is also a proposal to offset some outlays by collecting from private insurers for care of non service connected conditions. The most disconcerting proposal is to begin applying a "means test" to veterans seeking care from VA facilities, regardless of age.

Although no final regulations have been published, the Veterans Administration has announced its intention to look behind the poverty oath veterans must give in order to receive medical care for non service connected conditions. The "means test" to determine whether a veteran can afford care is anticipated to be one based on income formula; setting income cut-off levels for VA care. The failing in this simple formula method is that it does not consider a veteran's real ability to pay for medical expenses. According to a draft copy of the regulation, all veterans whose income (including spouses earnings) totals twice the amount of VA pensions, roughly $15,000, would be denied VA treatment if the care they need is expected to cost less than 5 percent of income. The scale, according to the draft, rises to 10 percent of income on earnings totaling more than $30,000. The draft does not consider the veteran's debts, the number of dependents reliant on the income, or even if the income is earnings of the veteran. Indeed, women veterans who have chosen to work in the home might be disqualified from VA treatment based on the income of a working spouse. At the same time, veterans who have insurance are certainly more capable of providing care than those who do not, but no consideration is given to this in the formula. Regretably, it is within the power of the VA to implement these regulations for veterans under age 65 without a change in law.

Yet, existing law has built a reliance among all veterans on the VA medical care system. The availability of medical care from the VA has relieved veterans of the responsibility to provide alternative resources such as private insurance. Many veterans have not planned for their medical needs, particularly in their retirement years. Moreover, it would be equally bad to provide care to a retired veteran living comfortably on a low income who owns his home and auto, while denying care to a younger veteran who may appear to have a comfortable income, but who in fact has house payments, auto payments, and dependents for whom he must provide.

As a result, NCOA believes it would be most inappropriate to summarily change a system without first considering its real effect on the veterans it has served. Furthermore, if change is made, consideration should be given to the fact that such a change would merely transfer responsibility for veterans care from the VA to medi-care and other federal programs. The chairman of the House Select Committee on Aging, in a recently published release, stated that all this proposal would do is shift the burden of care for 500,000 veterans to medicare at a cost of $600 million annually. The rest of the "savings" proposed by the institution of these regulations would be shifted directly to veterans. The association implores the committee not to allow such changes to occur.

Overall, the VA has proposed savings of approximately $2.7

billion over the next three years. The budget alleges that in spite of reductions of 4% in outlays for medical administration and research, 3% in medical care, and 4% in construction during FY 1986, the VA will provide a 6% increase in care to veterans. A major portion of the budget reductions are contingent on legislation reducing federal salaries by 5 percent in FY 1986, allowing the imposition of the means test discussed above, Congressional concurrence in reducing the number of operating beds and legislation allowing the Veterans Administration to bill private insurers for care provided to veterans with non service connected disabilities. All of these contingencies are requisite to achieving the budgetary goals outlined by the VA but NCOA doubts that all will pass. It is imperative then, that NCOA support an overall increase in the Department of Medicine and Surgery budget request in an amount sufficient to continue all medical programs at their current operating levels with reasonable increases in construction, research, and patient care outlays.

DEPARTMENT OF MEMORIAL AFFAIRS

The budget request for the Department of Memorial Affairs (DMA) includes a $97 thousand increase in spending over FY 1985. Additionally, some real growth is anticipated in the national cemetery system. Again, this growth is expected to be financed through employee reductions and anticipated salary cuts.

Notwithstanding the proposed reduction in employment, the program proposed for Memorial Affairs is generally very good. If there is a federal employee salary reduction, DMA could probably achieve its budgetary goals without reducing services to veterans. However, NCOA continues to doubt the possibility that federal employee pay will be reduced. If the Association is correct, the budget request for DMA would be rendered wholly inadequate.

Simultaneously, NCOA is concerned with the lack of a funding request to expand the cemetery system to accommodate some areas of special need that are not satisfied under the regional cemetery concept adopted by the agency several years ago. For example, the National Cemetery of the Pacific in Punchbowl Crater on Oahu is expected to close to new interments this year. Yet, no replacement cemetery is proposed. As a result, veterans in Hawaii and other areas of the Pacific will have to be buried in San Bernadino, CA. if burial in a national cemetery is desired. NCOA also believes consideration should be given to aquiring cemeteries, such as the one in Arizona, where states are willing to donate the facility if the VA will assume responsibility for its operation. Hopefully the committee will accommodate these issues in its budget request.

GENERAL OPERATIONS

This last major accounting area is also slated for reduced outlays during FY 1986. Once again the reduction is based largely on anticipated savings from a federal salary reduction and a reduction in the number of employees expected to occur as a result of regional office consolidation. Accordingly, NCOA believes this account, too, should be adjusted to more reasonably reflect the outlay requirements in the absence of a federal pay reduction and regional office consolidation.

CONCLUSION

In the past, NCOA has viewed VA budget requests as reasonably pragmatic reflections of the needs of the agency tempered by the ability of the Nation's economy to support those needs. Last year NCOA commended the agency for its budget presentation and, with only one exception concerning a Grace Commission recommendation on home loan programs, fully supported the request. This year, the Association regretably cannot offer such support or commendation.

The Association freely admits that it lacks the resources and, some might argue the competence, to comprehensively analyze and comment on the adequacy of the VA's proposal. Still, even a cursory examination of the proposal produces several conclusions. First, the budget assumes certain "savings" will occur as a result of a series of Congressional actions which are highly improbable if considered individually and virtually impossible if considered together. One or two might pass, but certainly not all. Second, the budget assumes continued effectiveness of the agency in the absence of substantial funding and administrative support; particularly in the area of loan guaranty and veterans benefit counselling. Third, with regard to loan guaranty, the budget assumes continued participation by lenders, veterans and after-market buyers of veterans loans. Finally, and most regretably, the budget assumes the veterans' ability to pay for services which previously had been provided by the VA. In short, the budget seeks to transfer the cost of providing many services from the government to the veteran.

Accordingly, the Non Commissioned Officers Association does not believe the VA budget request is adequate to meet the needs of veterans or to support the agency. As previously discussed, the Association recommends denial of funding for regional office consolidation, inclusion of funding for continued operation of the veterans home loan guaranty program, and inclusion of funding for cemetery aquisition. Additionally, we ask the committee to carefully consider the other suggestions NCOA has made.

Thank you.

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February 22, 1985

The Honorable John Paul Hammerschmidt
Committee on Veterans Affairs
U. S. House of Representatives
334 Cannon House Office Building
Washington, D. C. 20515

Dear Mr. Hammerschmidt:

Thank you for the kind reception you extended me during the February 21, meeting of the committee on the Veterans Administration budget request for fiscal year 1986. Since the House was in session and your presence was required on the floor you asked that I provide, for the record, the answer to the following question:

> Would an increase in Servicemen's Group Life Insurance cost the government any money?
>
> > Since SGLI is supported by premiums paid by participating servicemembers, the only costs the government would have to pay in connection with an increasing the maximum allowable coverage would be administrative (eg.-updating forms, literature, regulations, etc.). The amount is considered negligible.

Hopefully, this information will be helpful as the committee considers proposals to increase the SGLI coverage limit.

Thank you again for your courtesy in receiving me as a witness.

Sincerely,

Richard W. Johnson, Jr.
Director of Legislative Affairs

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STATEMENT OF

ROBERT O. MULLER

PRESIDENT

VIETNAM VETERANS OF AMERICA

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

February 21, 1985

Mr. Chairman, Vietnam Veterans of America (VVA) appreciates the opportunity to appear before this Committee to relate our views on the Administration's proposed fiscal year 1986 budget, as it affects veterans programs and services. We view this year as a particularly important year in veterans affairs, one in which decisions will be made which will profoundly affect veterans benefits for a generation. We appreciate the extraordinary efforts going on in this Congress to manage an unacceptable federal budget deficit. VVA is not so much concerned with actual dollars which may be trimmed from veterans programs, as much as we are in the process of determining from which areas those funds are to be taken. VVA does not believe that the veterans services system which has evolved over the past forty years ought to be changed piecemeal or subject to the ephemeral whims of ideology or politics. We are well aware that the VA's programs have been studied and restudied over the years, but the veterans benefits system has never been evaluated _in toto_ since the Bradley Commission under President Eisenhower undertook its review some thirty years ago. Since that time we have had two GI Bills, new pension programs, major changes in employment programs, as well as the evolution on a broad, national scale of human services and health care programs. A review of the entire benefits and services system would allow all of us-the Executive Branch, the Congress, and the veterans service organizations--to see, for the first time in three decades what the needs of our veterans really are. It will allow an evaluation of how well existing resources are meeting those needs, which programs may be antiquated or wasteful, and how the use of limited federal dollars may be optimized. VVA is currently developing a proposal for such a review mechanism which we will outline when we present our legislative agenda to this Committee on February 27, 1985.

The Administration's proposed budget which we are considering today does not, in our opinion, rationally and realistically consider the needs of veterans. Such needs we believe have been and should continue to be a high national priority. That much having been said, we must also note that on several major issues, we have been pleasantly surprised. We are pleased to note, for example, that a cost of living allowance freeze has not been imposed upon compensation and pension. An OMB budget paper which VVA obtained in December had originally proposed such a freeze on a number of programs, including compensation and pension. VVA does not in principle oppose such freezes, as long as they are fair and applied across the board to all income transfer programs. Since this is evidently not to be the case, we are pleased to see that the proposal was dropped, and a 4.1% increase authorized.

VVA is also pleased to note that the OMB recommendation to eliminate all National Programs under the Job Training Partnership Act (JTPA) has been dropped and that these programs including Title IVC, the National Veterans Job Training Program, will continue. We are disturbed however, over a cut of some $2 million for title IVC in 1986. It is our view that this program has been grossly underfunded, and is a vital tool to assisting non-job ready Vietnam veterans. VVA will be discussing this issue with the appropriate Congressional Committees in the coming months.

As we have indicated, we are encouraged by these apparent shifts in the Administration's policy toward veterans programs. We are not, however, in agreement with a number of other proposals contained in the budget.

VVA is very concerned over the future of the VA health care system, not so much by what is being proposed in the Administration's budget, but by what is left unsaid or unresolved. VVA wishes to make it very clear that we do not and cannot support any proposal which would deny a veteran health care who genuinely needs the VA. The proposed income test, by setting an upper eligibility level of approximately $15,000 is too low for VVA to support, particularly if that includes a spend-down provision under which the veteran would be forced to divest himself of all assets over $15,000.

In addition, apparently left unaddressed is how the proposed income test might affect veterans who have applied to a VA hospital for Agent Orange or PTSD related problems. It seems to us that the VA health care system in particular would benefit from a review and clarification of its mission and goals. An attempt to bring changes to a system such as this where the only objective is to save money, could be very damaging to the complex VA medical program.

A similar lack of objective analysis seems to attend the Administration's proposed consolidation of the Department of Veterans Benefits. VVA has long believed that DVB needs major structural changes, primarly to bring the Department closer to the veteran client and to create a closer network of veteran services at the community level. The proposed consolidation would do just the opposite by centralizing and isolating the adjudication process and leaving a skeletal staff which, in most locations, would be the only DVB office in the state. We find the proposal particularly objectionable in that it would centralize both the Rating Boards and elements of the Loan Guarantee Division. We are aware that the Administration is suggesting the creation of traveling rating boards, but VVA believes that there is no way these Boards could even approximate adequate service for veterans entitled to and requesting hearings. As this Committee is well aware, the Board of Veterans Appeals has had problems associated with traveling panels for years. VVA believes that consolidation will greatly increase delays associated with the adjudication of benefits. We are also frankly mistrustful and believe the time will come in the near future when the VA will return to this Committee asking for partial or complete elimination of the Regional Offices. Such depersonalization of the agency is clearly antithetical to the best interest of the veteran whom the Agency exists to serve.

Mr. Chairman, in regard to the VA Home Loan Mortgage Guaranty

Program, we urge you to secure passage of the full $404 million needed to maintain the revolving fund. This program has functioned well for forty years in its basic purpose of enabling the veteran of moderate means to purchase his or her first home. We believe that this was the primary intent of the act and the Congress has reaffirmed this intent many times since. VVA strongly believes that an origination fee of no more than 1% must be maintained in order to preserve the central thrust of this program. VVA will recommend in hearings next month before this body, that a number of changes be made in the program that will generate more funds to help keep this program stable, while preserving its original central intent. These recommendations include a 5% origination fee for "res~~orted~~ tored usage" participants, a 5% fee on non-veteran users of VA-vendor financing. ~~and a modification in accounting so that~~ all proceeds ~~for the sale of acquired properties go back into the revolving fund~~. This last recommendation addresses a key point, Mr. Chairman, which is that the Loan Guarantee Revolving Fund is still experiencing losses due to foreclosure and acquisition costs as a result of the aftermath of the 1982-83 recession and concomitant major economic dislocation. This recommendation would halt the "hemmoraging" of the revolving fund, to a large degree.

Mr. Chairman, Vietnam Veterans of America also calls upon you to do your utmost to preserve the U.S. Small Business Administration as an independent agency with a continuing strong program for veterans. In FY '84, the SBA assisted over 5,000 veteran owned businesses with long term financing, totalling almost $700 million dollars. This was almost 25% of all direct and guaranteed loans by the SBA. Perhaps even more importantly, Mr. Chairman, over 100,000 veterans received management assistance and training under the auspices of SBA, a great number of whom received such vital skill training as a result of the special veteran outreach program as SBA.

This is not a "cost" to the government, rather, it is an investment. SBA have added $468 billion to the GNP and returned $142 billion to the U.S. Treasury in taxes. VVA urges you to ensure that SBA is continued as an independent agency with an augmented management assistance and training staff and, at least, level funding of the $1.68 million in veterans outreach and training program funds for FY '86. Under the leadership of Jim Sanders and Marshall Parker SBA has made great strides toward being responsive to the needs and aspirations of veteran enterpreners. VVA asks for your leadership in preserving this investment in America's future.

Mr. Chairman, that concludes our remarks. I would be happy to answer any questions you or the Committee may have.

Written Committee Questions and Their Response

CHAIRMAN G.V. (SONNY) MONTGOMERY TO VETERANS' ADMINISTRATION

Question 1. In Volume II, Page 8-2 of your Fiscal Year 1986 Medical Programs Request, there is a summary of the request for grants to States for the acquisition or construction of state extended care facilities for eligible veterans. You have reported a backlog for such requests for these grants exceeding $150 million.

The Congress appropriated $34.5 million for this purpose in Fiscal Year 1985 with the intent that this backlog be cleared up in 3 to 4 years. Yet the program summary on this page indicates you will have an unobligated balance at the beginning of 1986 of nearly $10 million and your Fiscal Year 1986 budget request is for only $22 million. Please give the Subcommittee the specific reasons why this is so. Is it that the VA cannot process and obligate these funds or is there some other reason?

Answer. The unobligated balance at the start of 1986 of $9,889,000 is for the following projects and reasons:

Locality and state	Project	Dollars in thousands	Reason
Yountville, CA	Remodel Dom, life safety	1,054	⅓ limitation.
Paramus, NJ	New State home, 100-bed NH	338	⅓ limitation.
Jackson, MS	New State home, 150-bed NH	3,788	Insufficient funds.
Unknown	Estimated obligation increases	4,709	Reserve.
		9,889	

Based on an appropriation of $34.5 million, no one State may receive in Fiscal Year 1985 in the aggregate more than one-third ($11.5 million) of the amount appropriated for Grants for Construction of State Extended Care Facilities (reference 38 U.S.C. 5035(d)(2)). Estimated grant requests from California total $12.3 million for four projects. Therefore, one project cannot be funded in 1985 resulting in a $1,054,000 unobligated balance. Estimated grant requests from New Jersey total $16.3 million for three projects. Therefore, one project cannot be funded in 1985 resulting in a $338,000 unobligated balance. In order to fund the grant request from Mississippi in 1985, approximately $600 thousand more would be needed in the appropriation. For 1985, $4.7 million is estimated to be needed for obligation increases resulting from increased costs at the time of the construction bid over the initial obligation based on estimated costs. The increase is limited to 10 percent per project. Should these increased costs not materialize, such excess reserve funds would be available for the next project(s) on the list of eligible applications.

Question 2. The average total cost of constructing nursing home care beds in state veteran facilities is $33,851 per bed (reported on Page 8-3, Volume II). The average cost of similar construction in VA facilities in Fiscal Year 1986 is $51,940 per bed (see Pages 13-4 and 31-52 of Volume III)—some $18,089 more per bed or 35% above the per bed cost in state veteran facilities. In past fiscal years the difference in cost to VA versus state veteran facilities has been even greater. Members of the Committee have seen the facilities in both state veterans homes and the VA. The state constructed facilities are excellent.

Please give us the specific reasons for these major cost differences for the construction of similar facilities.

Does this not give even greater emphasis for assistance in states in this kind of construction and delivery of care?

Answer. The information in Volume II on page 8-3 is a combined list of all projects; nursing home, domiciliary, and hospital; construction, remodeling, and renovation; those with and without beds; and the total estimated cost of all these projects for each State home for the time period 1966 through 1984. This information is inadequate for computation of an average total cost of constructing nursing home beds in State veterans facilities. The VA estimates the average current cost of constructing State facilities for nursing home care at $56,138 per bed. This is based on 17 grant requests on hand at the time of final budget formulation in December 1984 totalling $128,950,000 for 2,297 beds. VA participation would be up to 65 percent of the cost, or about $36,490 per bed.

The standards for construction of VA facilities and State facilities receiving VA grants are similar as is the average cost per bed.

Since VA participation is limited to 65 percent of the cost of construction, expenditure of Federal funds for State home facilities rather than for VA nursing home facilities results in more nursing home beds per dollar appropriated.

Question 3. On page 5-9 of Volume II under Legislative Initiatives you propose to provide care, within the limits of VA facilities, to 7 different categories of veterans. Is the listing on this page in the order of priority that you would provide such care. If not, what would be the order of priority.

Answer. The listing is not in order of priority per se. We would provide care to service-connected veterans as a first priority. The categories 2-6 of our budget document would be grouped together as a second priority and nonservice-connected veterans who meet the criteria of the means test would be the 3rd priority.

Question 4. Please explain the statement under paragraph 4 on Page 5-24 of Volume II. We know positions under title 38 comparable to GS 11-15 were exempted from the grade reduction in fiscal year 1985. What happens in Fiscal Year 1986 and the out years as far as these positions under title 38 are concerned?

Is the bottom line that the reduction of funds are being applied to all grade GS 11-15 or comparable grades even though you say title 38 grades have been exempted?

Answer. Neither OPM or the VA are requiring Title 38 position reductions in FY 1985 or in any out years of the grade 11-15 reduction program. However, in FY 1985, Title 38 employees were included in determining recurring budget reductions. The inclusion of Title 38 employees in determining these reductions was successfully appealed, and as a result, additional savings in FY 1986-1989 will be based upon Title 5 positions only. The $5,305,000 generated by the Title 38 portion of the FY 1985 reduction has been restored to the FY 1986 budget.

Question 5. Under the legislative initiatives on page 5-9 of volume II there is indicated the desire to apply a means test for the treatment of nonservice-connected disabilities. Does the Administrator already have legislative authority to accomplish this?

Answer. The Administrator has authority to apply a means test to nonservice-connected veterans under age 65 only. This initiative would treat non-service disabled veterans similarily regardless of age. The means test would not be applied to veterans with any service-connected disabilities even in those cases when treated for a nonservice-connected disability.

Question 5(a). What is your estimate of the so called savings if this means test is applied?

Answer. Some of the details of the initiative are still under development and, therefore, we have not estimated the specific savings.

Question 5(b). Give us your estimate of veterans age 65 years or over who would be denied care in Fiscal Year 1986 if this is enacted.

Answer. Based on data collected by GAO who used our nonservice-connected inpatient population as a base, we estimate that approximately 9,800 veterans over aged 65 have sufficient resources to obtain care from other sources.

Question 6. On Page 5-9 of Volume II there is a statement that legislation will be proposed to require reimbursement from private health insurance plans where a veteran has such coverage.

Question 6(a). Explain to the Subcommittee how this would work. Would a service connected veteran, being treated for a non-service connected condition, have his private health insurer billed? How about former POW's? Vietnam veterans exposed to Agent Orange or veterans exposed to ionizing radiation? VA pensioners?

Answer. No recovery would be made from any veteran who has a service-connected disability even if the veteran were treated for a nonservice-connected disability. Recovery would be made from health insurance policies carried by nonservice-connected veterans. This would include nonservice-connected former POWs, those claiming exposure to Agent Orange or to ionizing radiation, and VA pensioners.

Question 6(b). What are the expected "savings?"

Answer. VA's estimate is still being developed and will be provided with legislative proposal.

Question 6(c). What, if any, would be the cost of revamping the VA cost accounting system to accommodate such legislation?

Answer. No change to the VA cost accounting system would be needed because of legislation to permit such recoveries.

Question 6(d). What would be the annual personnel cost to administer such a collection program?

Answer. See answer to "b" above.

Question 7. On page 5-16 of Volume II, Section 1.a.(3) there is indicated the conversion of 440 hospital beds to nursing home beds in VA Medical Centers with the conversion of $7.75 million and 220 FTEE for this purpose. Please identify the VA Medical Centers where this will occur together with the number of beds at each center, the funds to be converted and the FTEE to be converted.

Answer. The MEDIPP process identified the cumulative impact of the proposed budget actions of 172 medical centers. Within this total, the medical centers identified the following bed changes:

	Beds
Medical	−37
Surgical	−262
Psychiatric	−144
Intermediate	+239
Hospital	−204
Nursing	+204
Net Change	

The bed reconfiguration and conversion initiative included in the 1986 Budget not only identified those resources saved from reducing costly inpatient hospital beds but also the additional resources required to support the converted nursing home beds. Using current operating costs the resources reduced from inpatient (using the bed distribution identified by MEDIPP) would be $23,222,000 and 521 FTEE and the resources to support increased nursing home requirements would be $7,750,000 and 220 FTEE.

The hospital bed configuration/conversion will be operationally implemented as part of the resource allocation (target allowance) process. To the individual medical center involved, the "building-up" MEDIPP process (summation and interrelation of all initiatives used in formulating the 1986 budget) will be different from the "feeding down" process on budget implementation (which provides each medical center with the net result of all budget decisions). The total allocation process will ultimately establish the resource shifts at individual medical centers.

Question 8. On Page 5-26 of Volume II it is noted that only $3.1 million is being requested for computer systems equipment. This is $14.8 million below the Fiscal Year 1985 level.

Does this mean that an additional $3.1 million will complete the procurement of computer systems for all health care delivery facilities? If not, what is the estimated cost for the complete installation for the decentralized hospital computer system throughout the VA facilities?

Answer. By the end of 1985, all facilities will have received Initial and Full CORE equipment for DHCP. The $3.1 million requested includes equipment funds for construction/activation projects ($1,250,000), replacement equipment base ($1,477,000) and upgrades to systems software ($390,000). However, the department requested an additional $2,936,000 and 45 FTEE for enhancements to DHCP hardware and software and an additional $18,852,000 was requested for local field initiatives and office automation. The total final cost for an Enhanced DHCP is not known at this time. Current plans call for the integration of field office automation and local field ADP initiatives into the composition of DHCP. We are currently working to expand the scope of DHCP under the VA Modernization Plan. The three initiatives submitted were as follows:

DHCP equipment	$2,936,000
DHCP (V&DC FTEE)[1]	(45)
Field office automation	5,584,000
Local field initiatives	13,268,000
Total	21,788,000

[1] Funding to support the FTEE would have been provided through net reductions in other areas such as equipment maintenance, operating supplies, etc.

Question 9. On page 5-28 of Volume II concerning replacement building equipment, if I read the figures correctly, you are asking for $25.3 million in fiscal year 1986 to partially satisfy a current requirement of $165.2 million. Would you clarify this and state whether it will ever be possible to clear up this backlog or will you continue to drop further and further back as far as this deficit is concerned.

Answer. The replacement building service equipment backlog is different than normal equipment backlogs. First, the backlog is basically cyclical. That is, statistical replacement schedules are established for the replacement of certain items in a building (roof, boiler, etc.). The basic problem is that over fifty percent of the buildings were constructed between 1945 and 1955. This means that a majority of the buildings are between 30 and 40 years old. This is the time period when the projected life for many items expire. There are two outside influences which also impact this backlog. The inflation rate tends to increase the replacement cost. Also, the backlog is affected by the construction program. Since the total replacement requirements are developed independently of the construction program, when a replacement facility is constructed, the replacement requirements of the older facility are eliminated. The $25.3 million requested in 1986 will be for the highest priority projects to insure that facilities are maintained at acceptable levels.

Question 10. Please provide us with the information on object class 31 equipment that appears on page 5-27 of Volume II.

Answer. The 1985 replacement equipment funding level of $154,851,000 (page 5-27) represents a 10 percent increase over the 1984 actual level. The backlog, nevertheless, increased 43 percent in 1985 to a level of $309,857,000. The equipment requirements have increased due to inflation and the accumulation of prior years backlogs. Although backlogs result in maintaining pieces of equipment operationally longer than the anticipated life expectancy and prioritizing equipment needs within available resources, total elimination of the object class 31 equipment backlog is not considered desirable or achievable. In 1986 $161,801,000 is requested for replacement equipment which is an increase of $6,950,000 over 1985.

Question 11. Please provide us with your plans for future medical facility construction in the Gulf Coast area of Alabama and Florida, including Mobile and/or the Florida Panhandle. How does this fit in with your plans to activate a new outpatient clinic in Pensacola, Florida?

Answer. At the present time, no construction plans have been developed for an additional medical facility in the Gulf Coast area of Alabama and Florida. Activation of the new Pensacola, Florida Outpatient Clinic would have a limited impact on any construction planning due to the nature and types of care provided through an outpatient clinic versus an inpatient facility. The Pensacola Outpatient Clinic will be activated through leased space. If a decision is made to establish a new VA medical center in this area and if it is determined the Pensacola Outpatient Clinic is not needed, the lease for the clinic space could be terminated.

Question 12. On page 5-34 of Volume II reference is made to a reduction of $52.4 million and 1,916 FTEE in Fiscal Year 1986 due to a productivity improvement to be applied *"across the board"* to all medical care appropriation activities.

Does this assume all VA Medical Centers will improve productivity at exactly the same rate or does this really mean a "meat ax" approach of cutting the budget?

Answer. The 1986 employment level of 192,048 FTEE will continue to support the patients treated level included in the 1985 budget (about 1,280,000 patients treated). The net result of a productivity increase is that while average employment decreases, it is not accompanied with a corresponding workload decrease.

1. For the 1,916 FTEE to improve productivity, 32% of this reduction (613) will be assessed to all facilities based on the proportion of their indirect FTEE to all indirect FTEE. Indirect costs and costs not included in the Resource Allocation Models (for acute, ambulatory, and long term care) used for FY 86, average 32% systemwide.

2. The remaining 1,303 will be assessed to medical centers based on their relative efficiency as measured by methods derived from the Resource Allocation Models (RAMs). Under this method only facilities whose efficiency per direct care FTEE is below the system norms developed from the RAMs will be reduced on a proportionate basis. This will be applied to the 68% of facility costs that are direct medical care as measured by the RAMs.

3. All facilities will have some FTEE reduction calculated for their indirect costs and costs not measured by the RAMs, and some facilities will have FTEE reductions assigned to the direct services measured by the RAMs. However, the net reduction or gain in FTEE will not be assigned to any specific category and the facility directors will make the decision as to how the FTEE change should be spread.

4. Specific facility reductions are not available at this time, nor are the specific reductions by occupation known.

5. In line with the Administration's management initiatives, we are planning to conduct most efficient organization (MEO) reviews and expect that productivity improvements will be identified and pursued.

Question 13(a). Has the Nurse Scholarship Program been successful in recruiting and retaining nurses?

Answer. Yes, 273 professional nurses have been newly employed and another 97 VA nurses currently are in service obligation. One participant has completed service obligation and has been retained in VA. The mandatory service obligation prevents turnover that occurs most frequently in the first year of employment. However, at this time, recruitment and retention of nurses in general has improved due to the implementation of other special authorities, including the special pay provisions of P.L. 96-330. Recruitment and retention difficulties still exist in some geographic areas and in some nursing specialties, but in general, the recruitment of RNs is much improved since the severe shortage of the early 1980s.

Question 13(b). Did the VA request funding for the program from the Office of Management and Budget in Fiscal Year 1986?

Answer. Yes, the VA requested funding at the FY 85 level of $4.7 million and 8 FTEE for FY 86.

CONGRESSMAN JOHN PAUL HAMMERSCHMIDT TO VETERANS' ADMINISTRATION

Question 1. Do you believe it feasible to combine some small regional office processing functions with those of larger regional offices?

Answer. It could possibly be feasible to combine some smaller regional office processing functions with those of larger regional offices.

Question 2. Will the proposed phasing out of the Health Professional Scholarship Program adversely affect the recruiting for health care professionals?

Answer. There may be a minor affect on registered nurse recruitment, which is the only health care profession for which the scholarship authority has been used.

Although the program provided 200 nurse recruits annually—with their two year service obligation—other authorities, primarily special pay, are proving effective in recruitment and retention of nurses. Recruitment difficulties still exist in some geographic areas and in some nursing specialities, but in general, the recruitment of RN's is much improved since the servere shortage of the early 1980's. Many VA Medical Centers now have an adequate supply of nurse applicants to meet the past turnover rates of 4,000 nurses a year. An advantage of the Scholarship Program has been the visibility given to VA as an employer offering career opportunities for many who otherwise may not have consedered VA employment. This positive mechanism for recruitment will be lost.

Question 3. Do you consider the current law on priority for examination, and treatment for Agent Orange and radiation exposure to be effective and worthwhile.

Answer. Yes, this law has been beneficial to veterans who were exposed to Agent Orange and to those who were exposed to ionizing radiation. These veterans are not only receiving quality medical care, but their medical records are providing a data base for use in studies on possible health effects related to exposure. We do not support any change in this priority until after the completion of the CDC study and the decision of the Administrator.

Question 4. You recently commented on management improvements expected in outpatient clinics. This was in response to a GAO report. Would you please tell the Committee what the improvements will do in terms of number of patients treated, quality of treatment, etc.?

Answer. The General Accounting Office report confirms many of our own findings from the continuing VA effort to develop better methods of resource allocation and management control in the Department's ambulatory care programs. The GAO report and these VA studies demonstrate that the traditional methods of workload and resource assignment are not the most effective means of management of multi-institutional medical programs. We believe it is appropriate to gradually move the system toward a capitation allocation methodology which focuses on patients served in a given year. Such capitation can be both visit and person-based, depending on need or the type of incentives desirable by policy. The Chief Medical Director is considering implementing such a capitation methodology in FY 1986, to be phased in over several years with other techniques in acute and long-term care.

The VA is also working to improve the management of staffing in outpatient clinics, an area of concern reported in the GAO study. GAO's recommendations are consistent overall with VA's plans to improve the management techniques employed in outpatient programs. We believe such changes will enhance the quality of care of patients treated in VA clinics.

Question 5. How would you compare your costs of care in VA hospitals to those of the private sector?

Answer. Although we attempted previously several times to complete useful cost-comparisons, prior to the advent of the DRG classification system, available technologies have not been sufficient to account for inherent operating differences and other variations between the VA system and other health care institutions. Our most recent attempt to compare VA and private sector costs (in 1982) was criticized severely by the General Accounting Office, and that study has been discarded largely as a result.

Using DRGs and the VA's internal cost accounting system with an experimental model for allocating casemix resources to VA facilities, we have developed estimates of VA case costs by DRG. We believe these costs can form a basis for acceptable comparison with similar DRG costs from the private sector nationally. We can additionally discriminate between service-connected, non-service-connected pensioner and non-service-connected non-pensioner veterans in this analysis, and can display case—as well as per diem costs. To test the concept, we have informally cost-compared national VA costs to DRG data from all private hospitals in the State of Maryland. From this informal analysis, we found VA average costs to be roughly comparable to Maryland's costs, but reported cost variations between VA facilities are troublesome, unless we consider our role in research and education and specialized needs of veterans.

We are gathering data to conduct a broader cost comparison analysis. This study will address benchmark institutions and providers across the spectrum of U.S. health care. We are also consulting with DoD and HCFA to determine the usefulness of their data to this study. By late summer 1985, a draft report of this study should be available.

Question 6. Does your contemplated "means test" have a price tag on it for FY '86? *Congressional Quarterly* quotes some OMB spokesman as stating it saves some $300 million.

Answer. An estimate of savings has not been made.

Question 7. How could a "means test" save money if a needy veteran is admitted after a non-needy veteran is denied admission? Isn't the universe of qualified veterans so large as to preclude savings, especially as the typical veteran gets older and needs more medical care?

Answer. If non-needy veterans are replaced by needy veterans, no savings would be achieved by VA, although savings to the Federal Government for other health programs (i.e., Medicaid) might be realized. The universe of qualified veterans is very large as shown in the table below. However, the extent to which these veterans would now use VA is unknown since both geographic accessibility and personal preference could affect an eligible veteran's decision. We do expect the use of the VA health care capacity to be directed toward service-connected veterans, former POWs, veterans exposed to agent orange or ionizing radiation, pensioners, WWI, Spanish American War, Mexican Border period and other non-service-connected veterans who are truly needy.

Veterans in these groups are represented as follows:

Service-connected	3,760,335
Pension	780,515
POW	84,000
Atomic	200,000
Agent Orange	166,653
World War I (Total minus C&P)	183,000
Spanish American War and Mexican Border Period (Total minus C&P)	260
Non-service connected with limited incomes	5,864,000
Total	11,038,903

NOTE.—Double counting exists to some degree for POWs, Agent Orange and Ionizing Radiation.

SOURCE.—1,2,6, and 7 Administrator's Annual Report 1983.
3 DVB Tapes.
4 DM&S/Defense Nuclear Agency Estimate.
5 DM&S Examinations.
8 Office of Reports and Statistics Report, Dec. 1984.

Question 8. What would be the criteria of the means test?

Answer. Non-service-connected veterans whose annual family incomes including assets (as defined in the Improved Pension Program) are below double the maximum annual VA pension rate based on family size, would be deemed unable to defray necessary medical expenses. Out of pocket medical expenses for other family members would reduce the gross family income for determining eligibility.

For NSC veterans whose gross annual family incomes including assets are in excess of double the maximum annual VA pension rate, procedures would be established by regulation identifying the conditions under which veterans may be considered unable to defray further expenses and VA care could be provided for a particular medical service.

Except for veterans requiring emergency care and care in certain extraordinary circumstances, such veterans would not be eligible for VA health care until the veteran's out-of-pocket medical expenses exceed certain levels. These medical expense levels, are termed the "expected medical expense contribution."

For treatment of these NSC veterans, if the veteran is covered by a private insurance plan, the private plan would be required to reimburse the VA for medical expenses incurred by the patient that are covered by the plan. The VA would bill the veteran the difference between the insurance company payments and actual VA costs, but not in excess of the veteran's expected medical expense contribution.

WAIVER AUTHORITY

In exceptional, unusual, and rare circumstances, the Administrator could waive the veteran's expected medical expense contribution.

The Administrator would have authority to grant waivers for a portion or all of an individual veteran's medical expense contribution limited to the period of the episode of care for which the veteran claimed relief. Such waivers would only be considered upon application of the individual veteran, and a demonstration by the veteran that the contribution would effect an unusual and exceptional hardship on the veteran. Such waivers will not be granted categorically, either for categories of illness, expenses, incomes, procedures, or for veterans. The Administrator would issue regulations setting forth the procedures for granting such waivers. The Administrator's decision to grant or not to grant a waiver would not be subject to judicial review.

The expected medical expense contribution would form the basis of a means test procedure to evaluate the veterans inability to defray further medical costs. The following schedular display would be used.

Expected medical expense contribution as a percent of income in excess of double the pension maximum annual rate

Income Interval: [1]	
100-116.7	25
116.8-133.3	35
133.4-200.0	50
200.1-566.7	75
566.8 and over	90

[1] As a percent of double the pension maximum annual rate.

If the veteran presented reasonable evidence that out-of-pocket payments for his/her care to private providers and third parties during the preceding twelve months equaled or surpassed the expected medical expense contribution, the veteran would be admitted. The precise evidence acceptable to VA and pertinent to such claims would be defined in regulations.

Veterans requiring emergency care and care in certain extraordinary circumstances could be admitted for VA care, but would be billed for the cost of such care up to their expected medical expense contribution. These terms would be further defined in regulation. In addition, the veteran would be billed up to his expected medical expense contribution for any examination provided to determine if emergency care is required.

GRANDFATHER CLAUSE

This new procedure would be implemented prospectively; VA would not apply the means test for patients in a treatment status at the time of implementation of such new procedures. This grandfathering provision would apply only through the duration of the episode of care.

Question 9. What is your current backlog of requests for money for construction of State veterans nursing homes? If you had more money, could you effectively use it?

Answer. At the time of final budget formulation in December 1984, there were 65 eligible preapplications and applications for grants on hand totalling $151 million. Of these, 26 grant requests totalling $67 million are expected to be funded with the 1985 and requested 1986 appropriations. This would leave 39 grant requests totalling $84 million unfunded.

Effective use of the money would be dependent upon the States' ability to provide matching funds and submitting the final application, but it is believed that if the

States were infomed that Federal funds would be or were available, the States would expedite their processes in order to obtain the Federal Assistance funds. The delaying factors in using the funds in the first year year of the three year appropriation would be the States' ability to match the Federal funds and submit the final application, and the completion of the environmental review of the project by the VA.

Question 10. In the proposed $5.3 million and 157 FTEE reduction in medical and prosthetic research, how do you determine what research has low priority and what does not?

Answer. For Medical Research ongoing programs due for renewal with priority levels between 10 and 30 will receive support. Currently, programs with priorities between 10-34 receive funding. In addition to new programs, approximately 600 ongoing programs are reviewed for scientific merit each fiscal year and 400 with priority scores of 34 and below receive funding. With the resetting of the priority score cutoff at 30, approximately 40 programs will not be funded. These priorities are established by 14 boards of experts in program areas.

Health Services Research and Development and Rehabilitation Research and Development will maintain the same level of program.

Question 11. What is going to be the effect of the budget reduction for your medical research program?

Answer. In both Health Service Research and Development and Rehabilitation Research and Development no budget reductions are proposed. New programs will be initiated as ongoing programs terminate and can be replaced. No new initiatives will be implemented in 1986 for Medical Research and as ongoing programs due for renewal are reviewed, only those with priority levels between 10 and 30 will receive support.

Currently, programs with priorities between 10-34 receive funding. Medical Research will reduce the number of programs by 63 and FTEE by 157 below the estimated 1985 level.

This will result in an overall reduction of 40 investigator—initiated programs. In other areas of Medical Research, there will be a reduction of 2 cooperative study programs, 15 career development programs and 6 programs in the area of high priority.

Question 12. Even though there's an increase in nursing care FTEE, in the comparative employment ratios (at pages 5–36, Medical Programs, Vol. II), it appears that the FTEE for every 1,000 patients treated is reduced for VA nursing homes from 677 in 1985 to 657 in 1986. That is a decrease of 20 FTEE. Are these figures inconsistent? Is the decrease consistent with maintaining current levels in the quality of care?

Answer. The apparent fluctuation in the nursing staffing ratios can be traced to the impact of facility activations. In 1985, it is estimated that the number of nursing homes will increase by 11 from 105 to 116. The activation of a facility requires personnel to be on board approximately two months prior to activation. The result is that the staffing ratio for 1985 is temporarily overstated. This is further illustrated by the 1986 staffing ratio. In 1986, it is not estimated that any additional nursing homes will be activated but the workload (1985 annualized) catches up with the employment. The 1986 staffing ratio of 657 FTEE for every 1,000 patients treated is consistent with the actual 1984 staffing ratio of 654 FTEE for each 1,000 patients treated.

Question 13. The reduction of 450 FTEE in surgical bed sections seems to indicate a fairly major shift away from surgery. Is that correct? (If so,) in what areas are the reductions being made? At what facilities?

Answer. Disagree. We do not intend to shift away from surgery, but do intend to care for more patients in fewer beds by expanding ambulatory surgery, shorten length of stay, and convert some acute surgical beds to intermediate care beds assigned to Surgical Services. The figure of 450 FTEE is the result of bed reconfiguration to nursing and intermediate care beds based on the 1983 MEDIPP district plans. The locations for these reductions have not yet been determined.

Question 14. In some of the Western and rural states you use flying medical crews to deliver high quality medical care. Utah is an example. Is this a cost effective procedure as well as good medical practice?

Answer. The use of a chartered jet to transport subspecialty physicians is cost effective as well as good medical practice. The model is that physicians from the Salt Lake City VA Medical Center travel by chartered jet to the VAMC's Ft. Harrison, MT, Grand Junction, CO, and Miles City, MT. The VA Medical Center in Salt Lake is a tertiary VA hospital providing the most complex levels of care. The hospitals to which the jet flies do not have all modalities of care in terms of either specialty physicians or diagnostic and treatment equipment.

Since specialty physician care is not available at these medical centers, the alternative to the traveling physicians is for the VA to pay for the travel of its patients to a tertiary VA. Comparing the cost of travel for the patients being seen at the three outlying VA hospitals to the cost of the chartered jet shows a savings to the VA of over $400,000 per fiscal year.

The geographic area served by the subspecialty traveling treatment teams in sparsely populated and the population centers are separated by large distances. Part of the reason that the VA initiated this procedure was because of the high beneficiary travel costs associated with transporting patients over great distances. Utilizing the traveling jet clinics, the VA is able to provide subspecialty care to veterans who previously would not have received it or would have had to travel at considerable cost both to the VA and to themselves. Additional patients are receiving treatment and the quality of treatment is improved.

Question 15a. Where do you plan to locate the Prosthetic Center in Washington, D.C., when you move it from New York?

Answer. At the VA Medical Center, Washington, D.C.

Question 15b. Is there "move" money in the Fiscal Year 1986 budget for this purpose?

Answer. We are seeking legislative authority for a waiver of Section 210 so we can accomplish the move in FY 85. If this occurs, the "move" money will come out of the 85 budget. If it happens in FY 86, it will come out of the budget.

Question 16. Would you please comment on prescription costs in VA pharmacies as compared to Fee-Basis prescriptions?

Answer. In FY 1984, VA filled 43,097,478 prescriptions at an average cost of $7.13 (ingredient cost $5.76, labor cost $1.37). VA paid participating pharmacies an average of $12.20 each for 516,682 fee-basis prescriptions during the same period.

While no direct attempt is made to compare similar prescriptions (i.e., drug and amount), it should be noted that the patient population in general is the same in both groups, diagnoses are largely the same; and for the most part, refills of prescriptions originally filled by participating pharmacies are filled by the clinic of jurisdiction. Consequently, the cost data becomes a part of overall VA prescription costs.

Question 17. Have you made a comparison study of nursing home construction costs as between VA construction and private construction with a lease to follow?

Answer. The VA prepared a draft study comparing the total costs to the Government of a VA nursing home constructed, owned and operated by the VA versus a nursing home constructed and owned by private interest and leased to and operated by the VA. The preliminary findings of the study concluded that it was more cost-effective for the VA to construct than lease from the private sector a nursing home over a 20-year period.

This draft study was subsequently provided to the "American Health Care Association (AHCA)," an association which represents member nursing homes. Several meetings have been held with representatives of that association, including officials of the Americare Corporation of Columbus, Ohio. Copies of the study also were provided to Beverly Enterprises and several meetings and discussions have been held with that group. In addition, AHCA has made copies of the study available to some of their member groups, including the California Association of Health Facilities. The VA also transmitted a copy of the study to TransCon Builders of Washington, D.C., who in turn were going to provide VA with a copy of their financial analysis of a private sector nursing home care facility.

Comments were received from the various groups and pertinent exchanges made. In particular, Americare provided an analysis of the VA's draft Build/Lease Study to the Senate Veterans Affairs Committee (SVAC). The VA's response to the Americare analysis was provided to the SVAC during the FY 1985 budget deliberations.

Most recently, AHCA by letter of June 25, 1984, requested specific information from the VA to assist AHCA in their analysis of the Build/Lease Study. To date, we have not received AHCA's response to the data provided by the VA.

The VA still considers its draft Build/Lease Study a preliminary document and will continue to pursue further review and refinement with private sector groups. At this juncture, however, we find that our preliminary study finding that it is more cost-effective to build a nursing home rather than lease over a 20-year period is still valid.

Question 18a. Does VA contemplate a new contract with the new Hato Ray private hospital in Puerto Rico?

Answer: In order to meet the health care needs of veterans in Puerto Rico, the VA will continue to contract with the Hato Ray private hospital. The VA intends to enter into a new contract when the new Hato Ray facility is completed which is now anticipated for April 1985.

Question 18b. Just what are the VA's future plans in Puerto Rico and the Virgin Islands?

Answer: We have made great strides in alleviating health care delivery problems in Puerto Rico. The following are recent accomplishments:

1. The FY 1985 construction appropriation includes funds for a 120 bed nursing home with a 10 bed blind rehabilitation unit. The blind rehabilitation program has been initiated on a limited scale in FY 1984. We expect these two projects to be completed in 1988.
2. We have initiated the action that will result in establishing a VA-operated outpatient clinic in Ponce, Puerto Rico, to replace the contract outpatient program currently operating there. We expect that clinic to be operating in FY 1986.
3. We have initiated actions to improve the psychiatric hospital care program in San Juan through a more structured triaging of psychiatric patients and close monitoring of care provided our psychiatric patients in contract facilities. The latter of these activities has resulted in a 10% reduction in the average daily census in the contract hospitals.
4. We will be issuing a report shortly outlining the necessary steps to continue to provide care to veterans in Puerto Rico.

Question 19. At the VA budget briefing, you said any VA budget projection figures for FY 1987 and beyond would be "plugged" and "not drive by policy". I take "plugged" to mean essentially arbitrary. Would you explain what you meant by your statement?

Answer. The 1987 and outyear projections need to be revised based on national policy decisions to reform veteran eligibility requirements for medical care. These decisions will be reached after careful consideration of the views of veterans service organizations and all other interested parties.

Question 20. Mr. Walters, the proposed budget for medical construction is down $156 million. How was it decided what to cut or delay? What was actually cut or delayed?

Answer. OMB's guidance on the VA's major construction budget was quite specific. In the environment of the President's "freeze plus" budget, no funds were provided for projects which entailed additions or expansions to the system except for two Nursing Home Care Units and the Replacement/Modernization (R/M) category. In the R/M category, no additional design monies for new R/M projects were permitted but full funding of the main hospital replacement at Houston, full funding of the Mountain Home project, and initial funding to complete the Nursing Home Care Unit portion of the Philadelphia project was provided. In addition, no funding would be provided for laundry construction until OMB Circular A-76 analyses are performed to determine if such construction is cost-effective. All Department of Veterans Benefits proposed collocation projects were also denied until additional justification is provided which indicates increased efficiency and long-term cost reduction resulting from such collocation.

Within these parameters, the VA revised its budget request to OMB as follows:

REPLACEMENT AND MODERNIZATION

Seven R/M projects shown in the VA's current Needs Assessment for potential FY 1986 funding were not included in the VA's FY 1986 budget request to Congress. These projects are Allen Park (design funding), Atlanta (design funding), Augusta (construction funding), Dallas (design funding), Gainsville (design funding), New York (construction funding), and Pittsburgh (design funding).

NURSING HOME CARE

Five Nursing Home Care Units (Cheyenne, Ft. Wayne, Marion, IN, Martinez and St. Cloud) shown in the VA's current Needs Assessment for potential FY 1986 funding were not included in the VA's FY 1986 budget. In addition, the VA had one additional nursing home project (North Chicago) ready for FY 1986 budget funding consideration which was not included in the FY 86 budget.

RESEARCH AND EDUCATION

Two projects in this category shown in the Needs Assessment for potential FY 1986 funding consideration were not included in the VA's final FY 1986 budget request. These are at Omaha and White River Junction.

OUTPATIENT IMPROVEMENTS

One project in this category shown in the Needs Assessment for potential FY 1986 funding consideration was not included in the VA's final FY 86 budget request. This project is at Montgomery, AL.

CLINICAL IMPROVEMENTS

Four projects shown in this category in the Needs Assessment for potential FY 1986 funding consideration were not included in the VA's FY 1986 final budget request. These are at Beckley, Perry Point, Salt Lake City and Wilmington. One additional project at Oklahoma City shown in the Needs Assessment for potential FY 1986 budget consideration was not ready for consideration in the FY 1986 cycle.

GENERAL

Two laundry projects shown in the Needs Assessment for potential FY 1986 budget consideration were not included in the VA's final budget request. These are at Martinsburg and West Los Angeles.

In addition to the above revisions, two DVB collocations projects at Fargo and Wichita were not included in the VA's final FY 1986 budget request.

Question 21. Do you have any additional plans for contracting out? What is your current role with respect to OMB Circular A-76? Please answer with respect to the total VA and not just DM&S. Make specific reference to the question of contracting out dietetics.

Answer. On September 27, 1984, OMB issued new guidance refocusing the emphasis of OMB Circular A-76 implementation on the broader goal of overall productivity improvement, rather than strict contracting out. In accordance with this newly focused productivity improvement program, the VA submitted its Productivity Improvement/A-76 Plan to OMB on March 5, 1985 for final OMB approval.

The Offices of Construction, Administration, Procurement and Supply, Personnel, Data Management and Telecommunications and Department of Medicine and Surgery have scheduled specific activities (ADP Operations, Architect/Engineer, Audiovisual, Chauffeur, Data Entry/Keypunching, Design and Drafting, Fire Protection, Furniture Repair, Grounds Maintenance, Laundry/Dry Cleaning, Mail and File, Switchboard, Training, Transcription, VCS Food Service and Warehouse Services) for full productivity reviews culminating in cost comparisons to determine the most economical performance: by private contractors, other Federal Agencies, or in-house performance with Government Employees.

The Departments of Memorial Affairs, Veterans Benefits and Medicine and Surgery have also scheduled several specific activities (Cemetery Operations, Centralized Transcription Activities, Loan Processing, Mail/Messenger, Housekeeping, Plant Maintenance, Dietetic Foods, Medical Information and Office Operations) for Most Efficient Organization (MEO) reviews only. The Chief Medical Director determined on July 26, 1984, that in the best interest of patient care Dietetics would not be cost compared under A-76. This decision was endorsed by the deputy Administrator, and no further plans have been made to contract out this function. Dietetics will undergo a Most Efficient Organization (MEO) review in accordance with the OMB's new guidance.

MEO reviews are internal productivity assessments which determine the most efficient internal organization to perform a given function. These reviews stop with implementation of the most efficient organization and do not proceed to outside cost comparisons.

Pending OMB approval, the VA A-76/Productivity Review Schedule should be published in the Federal Register in the spring. The VA's first productivity improvement reviews are scheduled to begin in April 1985 for selected activities, with others scheduled during FY 1986 and FY 1987.

Question 22. How are your debt collection efforts progressing? What is the average debt? What is the default rate?

Answer. As of January 31, 1985, our Centralized Accounts Receivable System (CARS) was maintaining 1,139,371 accounts receivable valued at approximately $1.16 billion. This egates to an average debt of $1018. Cash collections and offsets from benefits totalled $367.5 million for fiscal year 1984 which was a 1.6% increase over fiscal year 1983. The VA's District Counsels continue to be effective in their litigation efforts which accounted for $14 million in cash collections during fiscal year 1984. The current default rate for the home loan program is 2.41%. Design specifications were completed in December 1984 for the referral of delinquent accounts to Credit Reporting Agencies in compliance with Public Law 96-466. We anticipate implementation in early 1986.

Question 23. Please discuss the effect of your legal actions to collect overdue debts.

Answer. The enforced collection effort conducted by the Office of General Counsel under authority of 38 U.S.C. § 3116 has shown dramatic improvement and proven to be a valuable source of revenue since it was begun. Cash collections have risen from $2.1 million in FY 81 to $7.9 million in FY 82, to $11.6 million in FY 83 to $14 million in FY 84. We are achieving collections of $2.68 for every dollar spent on the litigation effort. Of the total cases referred we estimate approximately 25% result in voluntary repayment plans. As of the end of January 1985, a total of 150,700 complaints have been filed in court and judgments have been entered in 76,600 cases. In addition, a significant number of cases are being disposed of as a result of this effort, through recoupment from other benefits, correction of records, waiver, etc.

Question 24. There has been talk of a super debt collection effort by one agency of the government. VA has a sizable debt collection program. What do you think of this idea?

Answer. We do not feel that a super debt collection effort controlled by one agency of the government would benefit the VA. The VA's accounts receivables, with the exception of education loan defaults or guaranteed loan/direct loan defaults are unlike most debts, which for the most part, are delinquent credit charges based on either a written or implied contract. The VA's accounts receivable are, for the most part, a result of overpaying VA benefits which are not contracted. In the event of a dispute, the burden of proof falls on the VA. Therefore, an outside agency could not respond to a dispute without referring the debtor back to the VA. This would result in additional costs over and above current VA collection costs. The VA would also be required to keep data current on all debts referred to another agency, resulting in additional costs.

Question 25. The Social Security Administration has been recently criticized for its automatic data processing activity. Without commenting upon that criticism, could you tell us how VA learns from other government agencies in order to always be up to the "state of the art"?

Answer. The VA keep abreast of the latest in state of the art technology through a variety of means. These can be largely grouped as interagency relationships to share and exchange ideas and information, participation and attendance in conferences and seminars, subscriptions to technical publications, training, utilization of automated tools for management and operational activities, and compliance with government directives which require continual review and evaluation of our resources and facilities. Although this grouping is not intended to be all inclusive, it is representative of the many government and private programs and activities the VA is involved with which continually promote our ability to be on top of the latest developments in data processing and telecommunications.

Question 26. What is the one time cost for moving the data processing centers and is "move" money in the fiscal year 1986 budget?

Answer. We estimate that the consolidation costs will be $3.6 million. This $3.6 million is included in the fiscal year 1986 budget.

Question 27. Does Austin and Hines have room for the moves from the data processing centers at Los Angeles and Ft. Snelling?

Answer. Both the Austin and Hines site do have sufficient room to house all of the equipment that would be relocated from the Los Angeles and St. Paul Data Processing Centers.

Question 28. Do you contemplate merging the VA Insurance function from Ft. Snelling, Minnesota, to Philadelphia, Pennsylvania? If so, what are the resultant savings?

Answer. We do not contemplate merging the two Insurance centers at this time.

Question 29. What is the cost of VA toll free telephone service across the country. What would be the consequences of its elimination?

Answer: The DVB (Department of Veterans Benefits) telephone service program consists of local, FX (Foreign Exchange), and 800 service lines, Zenith and Direct Distance Dialing services, and call handling equipment with management information systems. The approximate total annual recurring cost for the DVB telephone service program is $3,130,000. This includes costs for lines, services, and equipment, but does not include the cost of staff for answering calls since many employees are not dedicated solely to this task.

Elimination of the DVB telephone service program, particularly 800 service lines, would drastically decrease the equal accessibility for all persons to benefits information and assistance. The cost and burden to the general public, service organizations, congressional offices, and the DVB would increase greatly in trying to provide the same amount of benefits information and assistance service through correspondence or personal interviews. Generally, it takes four to six times longer to process a letter and to conduct a personal interview than to handle a telephone call. Annually, the DVB handles about four times as many telephone calls as personal interviews and correspondence combined. An available study has calculated a unit cost, including labor, per telephone interview and extrapolated unit costs for correspondence and personal interviews as follows:

Method of public contact:	*Estimated cost per unit*
Telephone interview	$1.01
Correspondence	3.83
Personal interview	5.60

In summary, the DVB telephone service program provides the most efficient and cost effective means for all persons to have access to information and help about veterans benefits. Such accessibility also frequently helps to reduce accounts receivable because the DVB is notified quickly of changes which affect the amount of benefit payments.

Question 30. What is the status of your pension investigation in Georgia and Florida? What does this portend for the entire nationwide VA pension program? Is there a 1986 budget impact?

Answer. The Inspector General's office began matching programs with States' wage records in 1984. Georgia and Florida were the first two matches.

The Georgia review is essentially complete. The Florida review is still in its early stages. Based on employment verified by the IG's office, claims have been/are being reviewed to redetermine entitlement.

In the review process any necessary retroactive adjustments, usually to reduce or terminate benefits, are made resulting normally in overpayments. Cases involving fraudulent claims are referred to the Inspector General for coordination with the U.S. Attorney for possible prosecution.

The majority of the cases arising from the matches are pension claims. A few compensation claims involving payment for individual unemployability have been reviewed.

The IG expects to continue its matching programs. As matches occur, the Department of Veterans Benefits will review and adjust affected claims. We do not anticipate any budget impact from the matches provided they occur on an arranged schedule which considers the normal regional office workloads.

The projected volumes of cases involved and adjusted nationally indicate that such matches are worthwhile. We are looking at ways to streamline the overall review process to minimize impact on workload.

Question 31. We hear stories of veterans remaining in VA hospitals in excess of 21 days for the purpose of receiving 100% compensation. Is this a problem and if so what is being done about it?

Answer. Only veterans who are hospitalized for longer than 21 days for treatment for service-connected disability can qualify for temporary payment of total (100%) disability compensation benefits. The temporary increase is allowed for only as long as treatment continues for service-connected disability.

While it is possible for a patient to try to manipulate a hospital discharge date to acquire entitlement to the temporarily increased benefits, we view the likelihood of success as extremely remote. Patients do not determine length of hospital stay. The physician's judgment is the deciding factor on need for and length of hospitalization. We have no evidence of doctor and patient collusion to take advantage of the system.

The trend, overall, in length of stay for hospitalization shows a decline from prior periods. Hospitalization for neuro-psychiatric disabilities has, for some specific types of mental disease, shown a slight increase for length of hospitalization.

CONGRESSMAN BOB EDGAR TO VETERANS' ADMINISTRATION

Question 1. Even assuming the enactment of legislation reducing the number of eligible veterans, the total number of veterans seeking health care from the VA is likely to increase. Yet, the budget assumes no increase in the number of patients treated. What provision is made in other programs to provide the medical care which these veterans will be unable to obtain from the VA?

Answer. We cannot speak for other Federal, state, local or private programs. The 1986 budget complies with the President's "feeze-plus" policy, yet it recognizes the VA's primary mandate to care for service-connected, special category, and poor veterans. The budget is sufficient for these expressed purpose in 1986. The Administration is still considering the aging issue overall and its potential out-year impact in federal medical outlays.

The legislation to be proposed will provide a means for the Agency to assure basic fairness and equity in the administration of VA health care benefits to all veterans who choose to use the VA system to meet their health care needs. This legislation also reinforces the VA's primary mission of providing medical care to service-connected and poor veterans. This is our understanding of the historical intent of Congress and this legislation simply will reaffirm that mandate.

Question 2. We are very concerned with the requirements stated in the VA's "Caring for the Older Veteran" report. Please identify alternatives being considered for meeting the veteran nursing home care requirements, including the reliance on other than VA programs?

Answer. First it is important to keep in mind that "Caring for the Older Veteran" is a series of options for meeting the health care requirements of the aging veteran population. As the Administrator of the VA has emphasized, the options in the report and the assumptions which underlie them can and must be debated. The issues in the report have major implications for the nation's health care system as a whole. Consequently, the Congress, the Veterans Service Organizations, the principal Health Care Financing programs and provider organizations must be involved together with the VA and other members of the Administration including the White House Health Policy Group in determining an affordable and acceptable way to meet the increasing needs. We expect that the necessary decisions will take a year or so.

Nevertheless, while the larger decisions affecting the entire health care system are being made, the VA has taken the challenge of dealing with the older veterans' needs very seriously and continues to be committed to providing high quality, comprehensive health care to all eligible veterans.

For the older veteran, this has meant incorporating special programs related to medical, psychiatric and rehabilitative care into existing acute care and outpatient programs, as well as expansion of several extended care programs.

To meet the projected increases in long term care patients, particularly those requiring nursing home care, several extended care programs are being expanded this year (FY 1985), and fully operational in 1986.

—Seventeen existing Geriatric Evaluations Units (GEUs) received an additional 2 FTEE per unit. The total number of units is 40.

—Six Hospital Based Home Care (HBHC) programs will be initiated, for a total of 49.

—Five additional Adult Day Health Centers (ADHC) will be in operation by the end of 1985, for a total of 9.

—Eleven new VA Nursing Home Care units are being added, for a total of 116. It is anticipated that the nursing home census will increase by 915 in 1985 to a level of 9975.

—Two more Geriatric Research, Evaluation and Clinical Centers (GRECCs) will reach full activation, for a total of 10.

—Thirteen State Home Care construction and renovation projects will be continuing as well as new ones initiated to support a State Nursing Home Care census of 8,200.

—Community Nursing Home census will be increased by 830 over the 1984 level, for a total of 11,439.

—Staff outpatient visits increased by 100,000 over the 1984 level of 17,035,000 visits.

Also, VA medical centers will continue developing joint planning, training and service delivery initiatives with Area Agencies on Aging, State Offices on Aging, and the broad aging network in the community, thereby enabling the VA and health-related community agencies to coordinate health care services so that they are complementary rather than competitive or unnecessarily duplicative.

A national training conference will be held in May, 1985, to focus on methods and strategies for expanding VA and community joint efforts in the coordination and integration of services for elderly "at-risk" veterans.

Question 3. Why is the estimated per diem for VA nursing home care considerably higher than that for community care?

Answer. Historically the average per diem cost nationwide of operating a VA NHC Unit has been higher than State homes or contracting for CNHC. One of the reasons is that the costs used to compute the average per diems have different bases. The VA nursing home care total cost is the summation of personnel and other costs incurred at those VA medical centers with nursing home care units. These costs have been distributed from organizational cost centers (i.e., medicine, radiology, etc.) to bed sections (i.e., medical, surgical, nursing home, etc.) based on estimates of usage of personnel time and other services rather than on the basis of individual patient charges for services received. The collocation of the VA nursing home with a hospital and the methodology for distributing all medical center costs may inflate the cost of VA nursing home care. Conversely, the community nursing home care cost is the summation of payments for care based upon negotiated rates for basic nursing home care services. Because of this the average per diem cost to the VA is most likely less than the national average per diem cost for all community nursing home facilities.

Another reason for the differences in per diem cost is that the services provided in VA facilities are not the same as those for which the VA contracts with community facilities to provide to a potential veteran placement. VA facilities provide a full range of services, without exclusion, to meet the varying needs of all veterans for nursing home care. Many patients need, and receive, much more intensive patient care services than the typical nursing home care patient. For instance, they require and receive specialized therapies and other services available at a medical center. On the other hand, VA contracts for basic nursing care services from community facilities for a negotiated rate. Community facilities generally will not provide a full range of services, such as occupational and physical therapy or expensive medications, to meet the needs of all veterans for nursing home care at a rate the VA is disposed to pay. Therefore, community nursing homes will not accept all patients that the VA proposes for placement at the contract rate, and usually exclude those requiring more than moderate patient care services. If more than routine services are required by a particular patient, such services are paid for separately or provided directly by the VA. The costs of such services are reflected in the community nursing home care per diem as part of VA support cost.

A third reason for the difference is that VA Nursing Home Care Units have a higher staffing cost than community nursing home care facilities. Cost of nursing services in VA Nursing Home Care Units is greater than the cost of nursing services in community nursing home care facilities due to a greater number of nursing care hours provided per patient per day and a higher proportion of licensed nursing personnel to nursing aides. Also adding to the higher staffing cost in the VA Nursing Home Care Units is the greater utilization of appropriately trained clinical dietitians, dietetic technicians, and food service workers.

Question 4. With 40 States presently maintaining a moratorium on nursing home construction, how comfortable do you feel in relying on the private sector to assist in meeting the demand for nursing home beds?

Answer. At present, there is no definitive answer concerning the extent to which the private sector will be able to assist the VA in meeting the growing veteran demand for nursing home care (NHC). The availability of NHC beds in the next decade or so will depend on many factors that are difficult to assess at this time. Nevertheless, in order to respond to a request from Representative Montgomery, Chairman of the House Veterans Affairs Committee on this issue, the Department of Medicine and Surgery asked the Institute for Health Planning, a consulting group, to examine this question, drawing on the planning data used by each of the States. They concluded that nationally during the decade of the 1990s there will probably not be a nursing home bed surplus and, in fact, that deficits are likely in many areas. They also found that expected hospital bed surpluses may be used to relieve some of the shortages they project.

The degree to which the projected deficits can be avoided will depend on the budgetary and regulatory climate that will exist in each state as well as on many potentially independent Federal, State and private sector decisions.

In its current projections for meeting the NHC needs of an aging veteran population, the VA is assuming that it can at least maintain its current percentage of penetration into the market. This will require at a minimum that the VA remain competitive in terms of the price it can pay for care and that the proprietary sector build sufficient numbers of additional beds. The current moratoriums on nursing home construction are based on currently perceived excesses of community nursing home beds. As these excesses diminish, the VA is hopeful that other sectors will respond by building additional beds. Whether the incentive for the proprietary sector to respond by building additional beds will exist in the future is dependent on many future economic variables which are difficult to forecast.

Question 5. Last year $34.5 million was appropriated for the State Extended Care grant program and the '86 budget requests $22 million. What are your plans for these monies? Have the increases in appropriations kept pace with applications filed by the States? Assuming the $22 million appropriation level in future years, how many years will it take to fund existing applications?

Answer. The 1985 and requested 1986 appropriations are expected to fund 26 grant requests totalling $67 million. Of the 65 eligible preapplications and applications on hand at the end of December 1984 totalling $151 million, 39 grant requests totalling $84 million will remain unfunded.

The increases in appropriations in the past have not kept pace with the dollar amount and number of applications on hand at the end of the year. From 1979 to 1984 the appropriation increased by 180 percent ($10-$18 million). During the same period, the backlog of applications at the end of the year increased in dollar amount by 318 percent ($38.7-$123.1 million). Assuming the $22 million appropriation level in future years, all the preapplications and applications on hand will be funded by the end of 1991.

Question 6. How will the increase in the number of presently eligible veterans affect the workloads of the VA health care delivery system?

Answer. The greatest increase in the number of eligible veterans will occur as veterans reach age 65. Data show that older veterans have greater health care utilization rates than younger veterans as exhibited by higher inpatient discharge rates and longer lengths of stay. This will to a great extent counterbalance the impact of the declining veteran population. The types of health care services needed by the aging veteran population will necessitate a greater emphasis on geriatric and extended care programs.

Question 7. Last year, the Department of Medicine and Surgery reported that VA medical facilities were turning away 250,000 eligible veterans annually. Have you prepared an update of this survey? Why not?

Answer. The HSR&D Service plans to repeat the survey during April 1985.

Question 8. How do you plan to reduce DM&S staff by 1,916 FTEE required by the 1% Management Improvements initiative?

Answer. The 1986 employment level of 192,048 FTEE will continue to support the patients treated level included in the 1985 budget (about 1,280,000 patients treated). The net result of a productivity increase is that while average employment decreases, it is not accompanied with a corresponding workload decrease.

1. For the 1,916 FTEE to improve productivity, 32% of this reduction (613) will be assessed to all facilities based on the proportion of their indirect FTEE to all indirect FTEE. Indirect costs and costs not included in the Resource Allocation Models (for acute, ambulatory, and long term care) used for FY 86, average 32% systemwide.

2. The remaining 1,303 will be assessed to medical centers based on their relative efficiency as measured by methods derived from the Resources Allocation Models (RAMs). Under this method only facilities whose efficiency per direct care FTEE is below the system norms developed from the RAMs will be reduced on a proportionate basis. This will be applied to the 68% of facility costs that are direct medical care as measured by the RAMs.

3. All facilities will have some FTEE reduction calculated for their interest costs and costs not measured by the RAMs, and some facilities will have FTEE reductions assigned to the direct services measured by the RAMs. However, the net reduction or gain in FTEE will not be assigned to any specific category and the facility directors will make the decision as to how the FTEE change should be spread.

4. Specific facility reductions are not available at this time, nor are the specific reductions by known occupation.

5. In line with the Administrator's management initiatives, we are planning to conduct Most Efficient Organization (MEO) reviews and expect that productivity improvements will be identified and pursued.

Question 9. Many of us have read the figures in the report entitiled "Caring for the Older Veteran" on the projected demand for health care by aging veteran. What concrete initiatives are in this budget to respond to aging veterans' needs?

Answer. Although the 1986 Budget request provides for modest program increases, the medical care appropriation includes several initiatives which provide the expanded health care to the aging veteran. We believe that the FY 1986 initiatives in combination with those covered by the FY 1985 current estimates, and the considerable progress made during FY 1984 amply demonstrates that the VA is continuing vigorously to plan and implement programs for the older veteran. The initiatives for the medical care appropriation are listed below:

(1) Provide resources to fully fund forty-nine Hospital Based Home Care (HBHC) programs. The 1985 budget provided first year resources for an additional six HBHC programs. In 1986 resources are requested to fully support these six programs. The total number of programs will be forty-nine.

(2) Census in VA nursing homes will increae by 866 in 1986. The additional census (for a 1986 total census of 10,841) will be provided by the conversion of 204 hospital beds to nursing home care beds (190 census), a realignment of resources from the hospital activity to the VA nursing home activity due to delays in facility activations (367 census), and scheduled activations in 1986 (309 census).

(3) An increase of 618 census is anticipated in the State Home Nursing Care program to a 1986 level of 8818. It is also estimated that the State Home Domiciliary census will increase by 248 to a level of 4717.

(4) It is anticipated that staff outpatient visits will increase by 120,000 in 1986 to a level of 17,155,000. This increase is the result of the anticipated impact of facility activations in 1986. Total staff and fee visits will be 18.8 million in 1986 (a 112,000 visit increase over the 1985 level).

Question 10(a). How many Magnetic Resonance Imaging (MRI) units does the VA have now and what was their cost?

Answer. We have purchased four units to date. The first was installed at VAMC St. Louis, Missouri, and became operational in March 1984. In September 1984, three additoinal systems were purchased, two were 1.5 tesla superconductive whole body units. (Tesla is the measure of magnetic flux density. One tesla is equal to 10,000 gauss, the older unit measure. The earth's magnetic field is approximately one gauss.) These units will be delivered in September 1985 to VAMCs Boston and Richmond, and the third unit was a 2.0 tesla, small bore animal research device that was delivered to VAMC San Francisco in December 1984. The cost of the machine was $880,000 for the lower energy St. Louis magnet; $1,451,150 for each of the 1.5 tesla whole body units, and $230,000 for the small bore San Francisco magnet. This equipment requires specially constructed facilities to prevent radio waves from outside sources from distorting the image, to provide a homogenous magnetic field insider the magnet and to prevent the machines magnetic waves from damaging anything outside of the scanning room.

Construction costs are estimated to be:

VAMC Boston	$1,700,000
VAMC Richmond	1,332,000
VAMC San Francisco	30,000

Question 10(b). What are the plans for future MRI procurements?

Answer. The Department of Medicine & Surgery has initiated a formal Technology Assessment program and as part of that effort has appointed a Technology Assessment Committee whose responsibility it is to recommend to the Chief Medical Director policy quiding the procurement of high cost, emerging, medical equipment. The Committee will furthermore be responsible for developing a scientific assessment of the safety, efficacy, and cost effectiveness of such technologies through a combination of formal literature review and primary data collection. The development of such data will enable the Department to create a two phased acquisition and deployment strategy which will be based on accepted research methods. The two phased process will consist of an acquisition of a small number of pilot test instruments located in VA facilities having the staff expertise, the research capability, and the related clinical programs and technical support necessary to mount such an effort. These pilot test stations will be responsible for generating the data necessary to justify further acquisition (or to discontinue any further acquisition) and serve as the basis for a deployment strategy. Data generated in this process will serve therefore not only as a defensible justification for procurement but will likewise provide a rational approach to siting such equipment throughout the VA system in an orderly, systematic sequence.

With this in mind the VA has three MRI systems either on line or in the process of activation and it is likely that either two or three additional instruments will be purchased this year.

These instruments will serve as the pilot test systems and will generate the data necessary for acquisition and deployment purposes. Our success will be determined by the availability of resources to purchase test instruments and to fund the research necessary to generate the required data. Over forty VA facilities have indicated a desire to have such equipment. It is not unreasonable to expect, based on preliminary information, that the VA will demonstrate the need for fifty to seventy such instruments within the next 5-10 years. The technology assessment process will be integrated into the Medical District Initiated Planning Process (MEDIPP) and will become part of the Department's long-range strategic management process.

Question 10. What will be the impact of eliminating MRI units from the FY '86 budget?

Answer. The elimination of the MRI program initiative from the '86 budget will delay the assessment of this important new technology and will impede its wide diffusion through the VA system. The data generated from the existing three MRI sites are less likely to be a valid and reliable base from which to draw to defensible conclusions and to serve as the foundation for either an acquisition or a deployment strategy, than would data generated in 5-6 such sites.

Reports in the medical literature would suggest that MRI is a valuable technolgy and has a positive impact on the quality of care provided patients. Should the acquisition of this technology in the VA system be delayed, there could be an increased cost during one year of providing the service because of the need to rely on contractual arrangements with the private sector. However, this would allow VA an additional year to learn from the experience of the private sector before making substantial investments.

Question 11(a). In view of the substantial investment and considerable progress made within the Department of Medicine and Surgery, will future ADP related modernization initiatives be compatable with the Decentralized Hospital Computer Program (DHCP)?

Answer. It is our intent that future ADP related modernization initiatives interface with the infrastructure of the Decentralized Hospital Computer-Program (DHCP). DHCP will make local information avialable locally. In addition, the Administrator's policies emphasize the value of each employee having appropriate online access to other VA information required by his or her position. Standards will be established to insure compatability of ADP structure within settings and necessary data exchange across settings.

Question 11(b). What actions do you propose to insure that additional ADP functions will be able to be integrated into the DHCP system? Will the Enhanced DHCP, the medical managment information, and the local initiatives mentioned in your February 1984 ADP Plan be incorporated into the modernization program?

Answer. It is our goal that Enhanced DHCP, local DM&S initiatives, and medical management infomation be an integral part of the modernization program. Automation of additional funcitions within the hospital will take full advantage of the ADP infrastructure of equipment and personnel already established to support Initial and Full CORE. This will provide a path to evolutionary additions rather than revolutionary disruptions. Integration of applications used within the hospital will be achieved through conformity to the standard data element dictionary. In addition to supporting day to day clinical and administrative operations, it is our intention that VA File Manager will be used to generate management information for local use and will provide input to central systems.

Question 12(a). For many years various reports have focused on the need for better managemnt information at all levels of the organization—from the field station level to the Central Office Level. What are your plans to modernize in this area and how will this be integrated with the DVB Target systems and DM&S DHCP systems?

Answer. VA plans focus on improving information systems in three areas: DM&S' specific systems, agency-wide systems, and links between systems. Plans for improvement of DM&S information systems will be detailed in a report to Congress due to be submitted in the Spring. In brief, DM&S plans to use DHCP operating software both to produce detailed management information for use by hospital managers and to report information to Central Office. Integration of systems will be achieved in two ways: substantively, by requiring that the data reported by hospitals adhere to standard definitions used in the Agency-Wide systems; and technically, by using DHCP computers to capture and transmit over VADATS data to support centralized systems. Work is already underway in both these areas. The DM&S data dictionary is being updated to include data elements generated in the hospitals for a centralized system in a manner consistant with DM&S and Agency policies and indicate in what different ADP systems the same data elements are being used. The Agency is also developing data dictionaries for its PAID and AMIS systems. The development and testing of input transactions from DHCP computers to the Patient Treatment File (PTF) at the Austin DPC was begun in 1984. With the completion of testing and distribution of DHCP software in FY 1985, PTF inputs will be transmitted from hospitals to the Austin DPC routinely.

Plans are also well underway to convert batch systems to on-line data base systems, thus providing VACO and field stations with access to corporate decision support data bases. Examples are the Payroll (PAID) system and Management Information System (AMIS).

Finally, efforts are underway to provide linkage between the DVB TARGET systems, the DM&S DHCP systems and other agency systems utilizing the VA Data Transmission Network (VADATS). Initially these interfaces will provide DM&S access to eligibility and benefits information maintained by DVB. Eventually this horizontal integration of Agency information will provide for the automation of manual forms processing between DM&S, DVB and other Agency Staff Offices.

Question 12(b). With respect to the modernization of the central data processing systems, such as the payroll system, what are your redesign plans to capitalize on the existing TARGET systems in the DVB Regional offices and DHCP systems in the DM&S medical centers?

Answer. Implementation of DHCP systems provides an opportunity to make the local data collection process more efficient and to make the data more accurate. Data for central system will not be created as a separate process (currently a manual one) but will be extracted from DHCP application files. With VA File Manager, data can be edited on site and therefore more accurate information will be available centrally and locally. Modernization of central systems such as PAID includes as part of their design the use of DHCP or other equipment to capture the necessary local data and to perform certain functions at the front end before transmission to the central system. The viability of using current TARGET capability in redesign of central systems is also being explored.

Question 12(c). Will there be separate equipment for different functions or a single integrated set of equipment for all functions?

Answer. Within the hospitals, there will be an integrated set of equipment for all functions. DHCP compatible equipment and VA File Manager will be used throughout the hospitals. This will both ensure that there is an integrated data base within the hospital and make the most efficient use of the on site ADP staff who are responsible for maintaining equipment and providing technical assistance. Using DHCP applications software, hospital staff will input data to the central systems such as PAID (payroll and personnel), CALM (accounting) and AMIS (workload). Centrally-processed information from these systems can, in turn, be downloaded to the hospitals. Technical interface of hospital systems and central systems such as TARGET which may use different hardware will be achieved through VADATS.

Question 13(a). Recently it was announced that the VA has awarded a rather substantial contract to WANG Corporation for the office automation. Does this mean that all VA facilities will now install WANG equipment?

Answer. The VA does not expect all VA facilities to install Wang equipment to meet their office automation needs. We encourage use of the contract; however, we recognize that some offices may have unique requirements or interface constraints that would be better served by use of equipment supplied by other vendors.

Question 13(b). Is this a mandatory requirements contract from which all Regional Offices and Medical Centers must order even though this equipment does not appear to be compatible with either the TARGET system or the DHCP systems equipment?

Answer. The contract negotiated with Wang Labortories does not obligate any VA facility to use the contract to meet its office automation requirements.

Question 13(c). Please provide for the record the total potential contract value, and the amount you plan to obligate against this contract for FY '85 and FY '86.

Answer. The total potential contract value is $60 million. Currently, we are preparing orders for FY '85 totaling approximately $2 million. Based on our projections for these users, approximately $1.7 million will be obligated in FY '86 against this contract.

Question 14(a). How many veterans do you estimate are presently eligible for Veterans' health care benefits?

Answer. There are approximately 11,038,903 eligible veterans.

These consist of the following groups:

Service connected	3,760,335
Non-service-connected Pensioners	780,515
Former prisoners of war	84,000
Atomic veterans	200,000
Agent orange veterans	166,653
World War I veterans (Total minus C&P)	183,000
Spanish American War and Mexican Border period (Total minus C&P)	260

Non-service-connected veterans with limited incomes	5,864,000
Total	11,038,903

NOTE.—Double counting exists to some degree for POWs, Agent Orange and Ionizing Radiation.

Source for answer to 14.a: 1, 2, 6, and 7 Administrator's Annual Report 1983; 3 DVB Tapes; 4 DM&S/Defense Nuclear Agency Estimate; 5 DM&S Examinations; and 8 Office of Reports and Statistics Report, Dec. 1984.

Question 14(b). How does this number compare with estimates of a year ago?

Answer. It has declined slightly due primarily to compensation and pension caseload reductions.

Question 14(c). How many veterans over the age 65 would lose eligibility if legislation is enacted to subject these veterans to a means test?

Answer. There are currently approximately over 90,000 non-service connected veterans, not in receipt of pension, and over the age of 65 who use the VA hospital system. Of this number, it is estimated that approximately 9,800 would lose their eligibility under the means test. Specific data by age and service-connected disability status are not available for outpatient care.

Question 14(d). What would be the staffing and funding requirements if the proposed legislation on third party reimbursement was enacted? What would be the resource requirements to implement your planned means test?

Answer. These estimates are still under development and will be submitted with our legislative proposal.

Question 15(a). Mr. Administrator, do you believe that the greying of the veteran population necessitates significant emphasis on the field of "geriatric medicine?" What I am trying to learn is your own personal views as to whether there will be real growth and significant shifts in the needs of veterans using the VA health care system.

Answer. The Veterans Administration has been aware for some time of the special needs of its aging client population. As a result, VA researches and clinicians have been at the forefront of the developing field of gerontology and geriatric medicine.

National health data show that American men 65 and over have more than twice the number of hospital stays per capita than do men in the 45-64 age group. Veterans' use of VA hospitals and outpatient clinics has a similar pattern. Those 65 years and older represent 31% of VA hospital discharges, and 28% of VA outpatient visits.

An older population experiences a different mix of diseases than does a younger one. Coronary and circulatory systems disease, respiratory diseases, neoplasms, organic brain disorders, and musculo-skeletal diseases, for instance, are more prevalent in those over 65. This group of diseases, while initially requiring acute care, tends to be chronic, progressive, and degenerative in nature, often causing permanent damage and requiring rehabilitation and/or long-term care. Older individuals often have more than one chronic condition, further complicating their clinical management and requiring more resources for their care. This has clear implications for staff recruitment and the retraining of existing staff.

Although considerable progress has been made in the past few years toward meeting the increasing care needs of older veterans, the challenge is still ahead. Older veterans represent the majority of patients being cared for in VA, community and State nursing homes. The average daily census and number of patients treated during the last year increased for all types of nursing home care programs. The increase in census for nursing home care and community residential care are expected to continue into the future along with an increase in patients treated in the Hospital Based Home Care Program. Many of these older veterans will need acute and outpatient services as well as a greatly expanded extended care capacity.

To meet this challenge, models of care are being developed, along with the traditional acute services, that respond specifically to the health needs of older veterans. The intent is to provide elderly veterans with a range of medical and health services that are designed to restore and/or maintain optimal health, foster independent living and improve the quality of life. This has clear implications for health services research and demonstration of continued efficacy of these needed approaches.

The VA medical care system is also giving considerable emphasis to the increasing medical care requirements of the aging veteran population by providing comprehensive, acute and long-term care; by developing and maintaining pertinent educational programs; and by carrying out a health services research program that strives to improve the status and well being of the elderly.

Question 15(b). What are your plans for increasing the staff of the office of the Assistant Chief Medical Director for Geriatrics and Extended Care to respond to the growing activity in this field?

Answer. The Chief Medical Director is in the process of reviewing the "macro" structure of the Department with the objective of improving management effectiveness and efficiency. Once this process is completed, a second level assessment will be conducted of selected organizations, including the Office of Geriatrics and Extended Care.

Like you, the Chief Medical Director is attentive to the escalation of activity in geriatric and extended care programs and the need to effectively develop and implement the best means of care for the increasing numbers of aging veterans.

Question 16. What is the staff reduction imposed on Central Office Management by the cut in the MAMOE account? What will be the impact of this reduction?

Answer. The cut in the MAMOE account, after adjustments for inflation, the GS/GM 11-15 Grade Reduction Program, the 5% pay reduction, and the 10% administrative overhead reduction, results in a total decrease of 107 FTEE.

Steps have been identified to make a gradual transition from the FY 1985 budgeted level (860 FTEE) to the FY 1985 supportable level (837 FTEE) to the FY 1986 supportable level (753 FTEE). These steps include a hiring freeze, consolidation of functions, identification of positions for possible reduction, exploration of an "early out" retirement program, and exploration, if necessary, of reduction-in-force procedures.

In the short-term, the most workable solution(s) will be identified to maintain continuity while reducing staffing. However, the reduction of 107 FTEE may lead to protracted results in some key areas, e.g., Staffing Guidelines and refining/documenting all aspects of the Resources Allocation Model, and the selection of less than optimum approaches to meet the objectives and timeframes of others, e.g., DM&S Occupational Safety and Health Program, MEDIPP, and development/enhancement of alternatives to institutionalized care for the aging veteran.

Question 17. What will be the impact if the 5% pay reduction is not realized and the funds not restored?

Answer. Based on an average salary of $45,000, not having the $1,240,000 restored will result in a further reduction of approximately 27 FTEE.

Question 18. What will be the impact of the $5.3 million reduction in Medical and Prosthetic Research?

Answer. In both Health Services Research and Development and Rehabilitation Research and Development the number of programs funded and FTEE will be at the 1985 level adjusted for inflation. New programs will be initiated as ongoing programs terminate and can be replaced.

No new initiatives will be implemented in 1986 for Medical Research and as ongoing programs due for renewal are reviewed, only those with priority levels between 10 and 30 will receive support. Currently, programs with priorities between 10-34 will receive support. Medical Research will reduce the number of programs by 63 and FTEE by 157 below the estimated 1985 level.

The program reduction will be as follows: (a) reduction of 40 investigator-initiated programs, (b) 2 cooperative study programs, (c) 15 career development programs and (d) 6 programs in the area of high priority.

CONGRESSMAN DOUGLAS APPLEGATE TO VETERANS' ADMINISTRATION

Question 1. Since you did not submit a detailed reorganization plan for reorganization in accordance with section 210(b) of title 38, U.S. Code, do you believe you have the authority to implement a reorganization involving consolidation of regional office functions in fiscal year 1986? When questioned at the hearing, you responded by saying this might be an alternative after developing a plan for modernizing your entire operations.

Answer. The letter of February 1, 1985 which reported the DVB regional office consolidation plan to appropriate committees of the Congress was timely and did contain some detail and justification for this proposal. Although extensive details were not given, the report did outline the basic framework of the proposal. Additional detail can and will be provided to the committees, as the report letter itself indicated, to facilitate adequate scrutiny of all aspects of the proposal.

As I indicated in my testimony, no final decision has been made as to the specific DVB proposal. We are considering various altenatives to modernize and make more efficient VA operations, including possible regional office consolidation.

Question 2. When questioned at the hearing on whether you believe you have the authority to implement a reorganization involving consolidation of regional office functions in fiscal year 1986, you responded by saying this might be an alternative after developing a plan for remodernizing your entire operation. This was not responsive to the question, which is: Since you did not submit a detailed reorganization plan on a timely basis in accordance with section 210(b) of title 38, U.S. Code, do you believe you now have the authority to implement such a plan in fiscal year 1986?

Answer. The letter of February 1, 1985 which reported the DVB regional office consolidation plan to appropriate committees of the Congress was timely and did contain some detail and justification for this proposal. Although extensive details were not given, the report did outline the basic framework of the proposal. Additional detail can and will be provided to the committees, as the report letter itself indicated, to facilitate adequate scrutiny of all aspects of the proposal.

As I indicated in my testimony, no final decision has been made as to the specific DVB proposal. We are considering various alternatives to modernize and make more efficient VA operations, including possible regional office consolidation.

Question 3. If the response to the above question is negative, do you plan to ask for restoration of the 624 FTEE which you expected to drop because of consolidation? If not, why not? It does not appear that you could successfully implement the modernization programs you described as in the planning stage by October 1 in order to achieve these personnel savings.

Answer. On February 11, 1985 a meeting was held between the VA Administrator and the Deputy OMB Director. At that time it was agreed that VA would develop a plan for modernizing its entire operations and will be considering various efficiency altenatives, one of which will be DVB consolidation. This effort has just begun and, when it is completed, a decision will be made as to the best course of action to be taken concerning DVB.

Question 4. You indicated in your testimony that you were developing a plan for modernizing the entire VA operation to achieve greater efficiency and that DVB consolidation would be one of the alternatives. The interest of the Committee is in knowing whether these potential changes could be developed, procured and implemented by October 1, 1985 and thereby impact on the fiscal year 86 budget. Would you comment?

Answer. No. We are not in a position to say at this time.

Question 5. Can you tell us if the regional office consolidation proposal came from the Grace Commission?

Answer. The report of the Veterans Administration prepared by the President's Private Sector Survey on Cost Control does not contain a specific recommendation regarding consolidation. The report includes an observation that the private sector has benefited from consolidating claism processing functions and relocating them to sites where labor is less expensive and employment tenure usually longer. The report also states that some consolidation of VA field stations may be necessary to achieve maximum efficiency.

Question 6. We saw in the Grace Commission report a recommendation that you assign responsibility for collecting new debts to regional offices where more aggressive methods could be used and centralize the hard-core uncollectible cases. Have you given this recommendation any consideration? If so please comment.

Answer. Due to the magnitude of the debt collection program, the requirements of both the Federal Claims Collection Standards, and the Debt Collection Act of 1982, and current resources, it is considered more cost effective to maintain a centralized automated debt collection activity.

CONGRESSMAN RICHARD SHELBY TO VETERANS' ADMINISTRATION

Question 1. If you already have the authority to set the maximum interest rate by law, what purpose would be served by the repeal of this authority? How would this benefit the veteran home buyer?

Answer. Although VA makes every effort to reflect the loan market in setting interest rates on guaranteed home loans, it is not always possible for such rates to keep exact pace with money market demands. When the cost of money is not adequately reflected by the VA interest rate, lenders are required to charge points to bring their yield into line with secondary market demands. One "point" equals 1 percent of the loan amount. The points must be paid in cash at loan closing. VA has interpreted the law as not permitting veterans to pay points, except under certain limited circumstances spelled out in section 1803(c)(3) of title 38, U.S. Code; e.g., refinancing and home improvement loans.

Sellers who are reluctant to pay points often either refuse to sell with VA financing, or increase the selling price of their home to reflect the anticipated points.

Under the proposal to "free" the rate from Administrative control, the veteran buyer, the seller, and the lender can negotiate what the interest rate will be and who will pay some or all of such points. Thus the transaction can be tailored to fit the needs and circumstances of the parties involved.

This change would also be consistent with the Administration's goal of reducing Federal regulation and permitting the free market to control.

Question 2. At last year's budget hearing you stated that since there was difficulty in developing consistency between the different agencies on a uniform foreclosure policy, your agency would "submit an appropriation to handle the revolving fund to acquire homes and to continue doing business as before, including employees". Did you not lose this 136 FTEE even though Congress refused to go along with the Grace Commission's proposed changes. The FY '86 budget shows an increase of 53 FTEE. Are Central Office's timeliness standards being met for all loan guaranty activities, particularly in property management?

Answer. The 136 FTEE specified in the FY 1985 budget was not restored to the Loan Guaranty Program. Timeliness Standards are being met in the appraisal and loan origination areas; however, the field stations are not meeting time standards in property management. The requested increase in FY '86 is expected to help alleviate this condition.

Question 3. The 1984 actual loss per defaulted loan was $8,504. In 1985, it is estimated at $11,376, and in 1986, you estimate an average loss of $14,613. Why is this figure substantially increasing yearly?

Answer. The loss on defaulted loan or claim processed average has been steadily increasing each fiscal year as loan amounts and housing prices rise. Higher interest rates also tend to increase claims. The average claim in FY 1982 was $4,328 and increased 52 percent to $6,570 in FY 1983. This was followed by another 30 percent increase in FY 1984. VA's projection for fiscal year 1985 and 1986 is in keeping with this trend. The higher amount can also be directly related to provisions of the Deficit Reduction Act (PL 98-369), which changed the criteria VA applies in determining net value of properties securing foreclosed GI loans. This change will result in fewer instances of property acquisitions and a greater number of cases where VA pays a gross claim. The higher frequency of gross claim payments is reflected in the averages for FY 1985 and FY 1986.

Question 4. Last fall, the Committee was informally advised that a report reassessing the regional cemetery concept, including alternatives to meeting veterans' burial needs, would be released in conjunction with the VA budget. What is the status of this report?

Answer. This report has been submitted to the Office of Management and Budget for their review and comments. Once it has received approval thru OMB, the report will be available for release.

Question 5. While I was out in Los Angeles last November, there was a press conference regarding expansion plans for the Los Angeles National Cemetery on adjacent land currently owned by the Veterans Administration. It is my understanding that this activity has been curtailed. Why is this so since the property belongs to the VA and can't be used for anything else?

Answer. In compliance with the Administration's efforts to reduce the budget deficit, the Department of Memorial Affairs has submitted a very austere budget for FY 1986. Resources that would be utilized to support the opening of the Los Angeles Cemetery will be redirected to support higher Departmental operating needs. DMA anticipates that Riverside N/C will partially support the burial requirements projected for Los Angeles N/C.

CONGRESSMAN THOMAS A. DASCHLE TO VETERANS' ADMINISTRATION

Question 1. Public Law 98-543 established two new cost saving programs which will be the responsibility of the Vocational Rehabilitation and Counseling Service.

One program authorizes vocational rehabilitation for service-connected disabled veterans with a total disability rating due to individual unemployability. The other authorizes vocational training for veterans newly entitled to pension payments who can be rehabilitated. There will be no savings for these programs until 1987.

Notwithstanding, you have these two new cost-saving programs. I understand that there are no additional employees for the anticipated increased workload. Recently, the vocational rehabilitation specialists and counselors came to Washington and met with Chairman Montgomery and others here in this Committee hearing room. They were in total agreement that additional employees were needed and more funds required if they are to fully carry out their mission. One vocational rehabilitation specialist indicated that he had used his own funds to make the trip to Washington. This shows how dedicated these people are, but there are limits on how much they can do with the funds available. Now you have two additional programs.

Is it true that you did request an additional 23 FTEE for these two new programs, but the Office of Management and Budget turned you down?

Answer. An additional 23 FTEE was requested for FY 1985 and 37 FTEE for FY 1986. The FY 1985 FTEE was not approved, however, an additional 10 FTEE was approved for FY 1986 over the FY 1985 authorization.

Question 2. Don't you agree that these additional employes are vital to the success of this program?

Answer. These programs have been implemented and will be carried out to the best of our ability with the resources allocated.

Question 3. One of the newest veterans' programs is the Emergency Veterans' Job Training Act authorized by Public Law 98-77. This law authorized a two-year program of $150 million for each year. The administration requested $150 million for fiscal year 1984. No additional funds have been requested for fiscal years 1985 or 1986. To date, over 23 thousand veterans have been placed in job training slots under this program, with approximately $92 million having been committed. Under Public Law 98-77, veterans must receive a certificate of eligibility by February 28, 1985, and be in a job by September 1, 1985. Funding expires fiscal year 1987.

Despite the disappointment that this program has not been utilized as fully as expected, it nevertheless has wide-spread support both in and out of government, and employee participation has greatly increased.

At a field hearing last week in Miami, Florida, witnesses representing both the veterans community and Government officials working with this program, expressed their strong support that the job training program be continued and expanded beyond its present delimiting dates. One of the principal reasons cited for continuing this program is the cost savings that are realized by getting long-term unemployed veterans off welfare assistance programs and converting them to productive tax-paying individuals.

Mr. Administrator, you indicated that you would recommend approval of this program when you appeared before this Committee in the 98th Congress. In the event this Committee should pass legislation to continue or expand the EVJTA, can we again look for your support and recommendation to have such legislation approved by the President.

Answer. Due to the economic recovery there will not be a need for further appropriations to fund the Emergency Veterans' Job Training Act.

Although 24,000 veterans have been placed in a training program, there were 87,000 fewer Vietnam era veterans unemployed in January, 1985 than there were in January, 1984.

Question 4. Title III of Public Law 97-72 established a small business loan program for disabled and Vietnam veterans to be administered by the Veterans Administration as part of Chapter 37, title 38, U.S. Code.

Unfortunately, the VA never requested the funds authorized for this program. Congres, however, added funds to implement the Veterans Small Business Loan Act of 1981 in appropriations for the Small Business Administration. The SBA has established an Office of Veterans Affairs in its central office in Washington, and Veterans Affairs Officers in each SBA office to administer this program.

The President has recommended that the SBA be abolished. With this in mind, has the VA taken any affirmative action to have the veterans' functions of the SBA transferred to your agency? Does the VA have any pans to assume responsibility for this veterans' program, which should have been a responsibility of your agency from the beginning? What are your views on this?

Answer. As of this date, the Veterans Administration (VA) has not taken any action or developed plans to have the veterans' functions of Small Business Administration (SBA) transferred to this agency. The VA currently does not have the specialized loan administration personnel or expertise necessary to perform the veterans loan programs of the SBA. Should Congress discontinue SBA as a separate Federal agency and transfer its functions to existing Federal agencies, the VA could serve as an appropriate agency for SBA veterans' functions. However, a separate specialized staff, such as accountants, commercial appraisers, and business liquidation specialists would need to be recruited to administer a business loan program at both the Central Office and regional offices level and necessary funds to implement such a program would be required.

It should be noted that VA already administers an active outreach program to assist Vietnam era and disabled veteran owned and operated small businesses in identifying business opportunities through our Office of Small and Disadvantaged Business Utilization.

Congressman Alan B. Mollohan to Veterans' Administration

Question 1. Public Law 98-223, authorized the extension of the state matching grant program through fiscal year 1989. The FY '85 appropriation is $5 million. I note that your request for FY '86 is only $3 million. This is a substantial reduction. What are your reasons for this reduction? Since no state may receive in any fiscal year a total amount in excess of 20 percent of the total appropriated amount, won't this have an adverse impact on some states who wish to apply?

Answer. The reduction in the State Cemetery Grant Program of $2 million should have no adverse effect on the grants program. It is anticipated that funds from prior years in the amount of $5.6 million will be carried forward to FY 1986. The funds available for expenditure in FY '86 would, therefore, be $8.6 million and a state could receive a grant of up to $1.7 million. The average grant has been $550,000, thus, the available funds can fund a maximum of fifteen states at $550,000 or a minimum of five at $1.7 million. During the five years ending September 30, 1984, 12 grants have been awarded to eight states. In addition, funds have been obligated for a cemetery on the Island of Guam.

Question 2. As a result of the aging veteran population, the FY '86 budget reflects increased interment projections, increased headstone applications, and an increase in burial plot allowances. Why then does the budget reflect a decrease in payment of the non-service-connected burial allowance. Additionally, why has average employment been reduced by 57 FTEE?

Answer. The burial allowance payment is restricted to veterans in receipt of, or entitled to, compensation or pension at time of death. Since the number of veterans receiving compensation or pension is projected to decline, the annual payments for burial allowances is also expected to decline.

Department of Memorial Affairs average employment for FY 1986 reflects a net reduction of 57 FTEE. A total of 73 FTEE was reduced in anticipated savings from further contracting out Departmental activities at VA national cemeteries. This reduction is partially offset by an increase of 16 FTEE to support the activities at both the Ft. Mitchell and Bay Pines National Cemeteries.

Congressman Tim Penny to Veterans' Administration

The following questions relate primarily to the proposed closing of the Veterans Administration Data Processing Center located in St. Paul, Minnesota. We, the other seven members of the Minnesota Congressional Delegation and myself, are very concerned over the loss of approximately 115 good and productive employees to our state, as well as the loss of an outstanding, cost-effective operation for the Veterans Administration. We have expressed our concern in a delegation letter to Mr. Stockman at OMB and I would now submit these questions for your complete explanation.

Question 1. Please submit a complete cost-benefit analysis which includes a complete justification for the decision to close the St. Paul facility.

Answer. The VA examined three major avenues of reducing operating costs of ADP and telecommunication services. They were: increased productivity and contracting out (A-76); attrition of on-board staff; and consolidation. Current plans include using all three approaches to reduce the costs of ODM&T operations. Each is examined further in the attached preliminary analysis. With respect to consolidation, since the costs of closing a site would be in proportion to the staff size of that site, we evaluated candidate sites for closing in order from the smallest to the largest. The smallest ODM&T field station is the Romney site, with Los Angeles and St. Paul next in order of staff size. With regard to the St. Paul Data Processing Center specifically, the attached preliminary analysis indicates that closing that site would reduce our operating costs with no reduction in services to the veteran. The analysis reflects budget estimates and the expected result of consolidating our DPC's. A more detailed analysis will be conducted once our detailed plans for the closing have been more fully developed, and the expected costs are more refined.

REDUCTION OF OPERATING COSTS, OFFICE OF DATA MANAGEMENT AND TELECOMMUNICATIONS

Introduction

The President has called upon all Executive Agencies to develop ways to reduce government costs by making government operations more efficient and effective. The Veterans Administration has proposed a Fiscal Year 1986 budget which strives to improve our efficiency in delivering benefits and services to improve our efficiency in delivering benefits and services to veterans and eligible dependents. As a consequence, we in the Office of Data Management and Telecommunications have been challenged to review our operations and develop more cost-effective means to provide the current level and scope of services without impairing the mission of the Agency. In response to this need, the Agency has proposed consolidating activities from the Los Angeles and St. Paul Data Processing Centers (DPCs) to DPCs at Austin, Hines and Philadelphia and the Romney, West Virginia, VADATS Message Switching Center (MSC) to the Austin MSC.

Objective

To provide the existing level of ADP support for veterans' programs at lower cost to the government.

Background

A review of ODM&T operating costs reveals that two major categories of cost are incurred on an annual basis. These costs are for personnel and technology. Personnel costs are primarily salary costs for FTEE resources. Technology costs include purchase, rental and maintenance of equipment, facility rent and maintenance, and other similar services. Both personnel costs and technology costs must be considered when reviewing alternatives to provide existing services with fewer dollars.

Cost Reduction Methods

There are three major avenues to reduce operating costs of VA ADP and telecommunications services, without adversely affecting the delivery of services to veterans. These are: (1) improved productivity and contracting out where appropriate (A-76); (2) attrition of on-board staff to realize the benefit of productivity gains and reduce FTEE costs to the VA; and (3) the consolidation of current activities to achieve both FTEE and technology cost reductions.

Current plans include using all three approaches to reduce the cost of ODM&T operations. Each is examined further in the context of the present operating environment.

(1) Productivity Reviews and Contracting Out.—The VA has established a plan for productivity reviews and A-76 studies for its ADP and telecommunications activities. The earliest productivity reviews are to be completed in the third quarter of Fiscal Year 1986, and the earliest cost studies are to be completed in the first quarter of Fiscal Year 1987. None of these will identify potential cost-savings until late Fiscal Year 1987. They may not be accelerated because of the complex procedures for conducting the A-76 studies and procurement actions. Contracting out will not reduce operating costs by any significant degree until Fiscal Year 1988 and beyond. A summary of the scheduled activities in the VA plan is as follows:

OMB CIRCULAR A-76 PRODUCTIVITY IMPROVEMENT PROGRAM REVIEW SCHEDULE

	Fiscal year—															
	1985				1986				1987				1988			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Austin DPC						X	X	X	X	X	X	X	X	X		
Hines DPC				X	X	X	X	X	X	X	X	X	X	X		
Philadelphia DPC								X	X	X	X	X	X	X		
St. Paul DPC									X	X	X	X	X	X	X	X
Los Angeles DPC										X	X	X	X	X	X	X

Attrition of Existing Staff.—Attrition is the reduction of FTEE costs achieved by not filling vacancies created by employees who leave ODM&T.

ODM&T currently experiences an attrition rate of 300 technical FTE per year. While the attrition rate would seem to result in a significant reduction of FTEE in nine months, there are several critical issues that make this unlikely.

First, with declining numbers of government ADP jobs available, it is not clear that the rate of attrition will continue at that level. A large amount of current ODM&T attrition is caused by movement of employees to other federal agencies.

Second, ODM&T services are provided from seven operational centers around the country. With over 100 job classifications for highly specialized ADP and telecommunications skills and the numbers of operational elements required to provide around the clock computer services, many technical staffs are already very small and a one FTEE reduction may amount to one-fourth of the staff. Most of those staffs could not be reduced without disrupting operations or services. Frequently, the more highly skilled (and mobile) employees must be replaced in order to assure technical direction of computer operator, data technician, and management analyst are not interchangeable; retraining and development cannot be quickly or cheaply accomplished.

Third, based on the expected Fiscal Year 1986 3.5% salary shorfall because of the Fiscal Year 1985 pay raise, ODM&T may have to use attrition to reduce an additional 65 FTEE by the end of Fiscal Year 1985

We don't believe that ODM&T can maintain the administrative and operational FTEE overhead associated with seven separate operational sites. Thus, attrition does not seem to be a viable alternative. This conclusion is further reinforced by the significant potential outyear FTEE reduction projected for productivity reviews and contracting out activities.

It would be easy to assume that a significant reduction of staff could be accomplished via attrition were it not for the highly specialized skills and relatively small numbers of FTEE providing specific areas or types of service. In many cases, the individual technical skills are unique to a specific operation, a specific service or a specific application system. An analyst cannot be as equally competent on several applications as on one, nor can the existing level of support be provided by fewer analysts. The same is generally true of other specialized skills.

An analysis of the skills and job titles of the Fiscal Year 1984 losses, and the location where the losses occur, indicates clearly that the loss pattern does not match the staffing requirements of the current workload. In order to effectively and efficiently operate a data processing center, develop essential new applications, enhance existing applications, maintain the many other system applications, and produce the required output products, replacement of losses in the critical support areas is essential to success. The turnover rate at our five data processing centers varied from a low of 9.6% to a high of 71.8% for Computer Programmers. The rate for Computer Analysts/Specialists varied from a low of 9.7% to a high of 100%; the rate for Computer Operators ranged from 4.5% to 20%; the rate for Data Transcribers ranged from 4.8% to 100%. The overall loss ratio at these sites varied from a low of 16% to a high of 31.8%. These wide variances in the turnover (loss) rates at the data processing centers and within the various job categories at each site preclude the use of normal attrition to reach lower staffing levels, and still provide the same level of ADP and telecommunications service required by VA departments and staff offices. Attrition could only be permitted where the services provided are performed more efficiently or with lowered overhead. Our ongoing work measurement studies lead to the conclusion that very small reductions in FTEE costs may be realized, and this avenue will be pursued through productivity reviews.

(3) Consolidation of ODM&T Activities.—The consolidation approach includes reviewing of existing ODM&T activities to ascertain what efficiencies and savings may be achieved through combining similar activities and eliminating overhead costs where possible.

In order to significantly reduce Fiscal Year 1986 operating costs, both FTEE and technology costs must be reduced by October 1, 1985. ODM&T facilities differ significantly in size and scope of operations. This affects how consolidations may be considered in order to reduce costs.

The matrix below identifies key factors to be considered and their relative degree of impact among the existing activities:

Facility	Nos. of FTEE	Application/service transportability	Current cost per square foot	Potential personnel costs of moving activity	Cost to replace facility	Cost to relocate equipment
Austin	588	Complex	Moderate	Very high	High	High.
Hines	406	Very complex	Low	Very high	High	High.

Facility	Nos. of FTEE	Application/service transportability	Current cost per square foot	Potential personnel costs of moving activity	Cost to replace facility	Cost to relocate equipment
Philadelphia	190	Complex	Moderate	Moderate	Moderate	High.
St. Paul	115	Simple	High	Moderate	Low	Low.
Los Angeles	43	Simple	Very high	Low	Low	Low.
Romney	30	Simple	High	Low	Low	Low.

An examination of this matrix based upon existing operating costs and expectations reveals relatively higher unit costs for the smaller facilities. This is true in potential FTEE costs to achieve consolidation, in potential disruption of services, in facility costs, in costs to replace existing facilities at another location, and in the projected costs to relocate and operate existing equipment. Among the smaller four facilities, only the Philadelphia services could not be provided from another location at present. This is because the presently used technology requires the co-location of the computer system and users. The services provided by St. Paul, Los Angeles and the Romney MSC can be provided from other locations without adverse impact on veterans' programs.

Specifically, the benefits of consolidation would appear to include the closing of the Los Angeles and St. Paul Data Processing Centers (DPCs) and the Romney MSC. By transferring equipment, applications, and limited FTEE to remaining DPCs, this option would result in approximate FTEE savings of 38 from Los Angeles DPC, 58 from the St. Paul DPC and 17 from the Romney MSC for a total permanent reduction of 113. At each location, the FTEE savings is a direct result of the fact that certain work currently performed at each location is already being performed at the facility of consolidation. To illustrate, an existing computer shift operation does not necessarily require additional FTEE because additional application programs are added to the workload. Essentially, the consolidation is in large part a decrease of workload at the losing site with an equivalent increase at the new location. To a great extent this increased workload can be handled with no supplement in staffing levels and no adverse impact on level of service. The consolidation of our operations will provide the existing level and schedules of services to VA organizations, and permanently reduce the overhead associated with maintaining the three facilities.

The specific implications of consolidation for each facility include:

Los Angeles DPC

Closing the Los Angeles DPC and moving the service activities to the Hines DPC would entail the following: move all hardware and software from Los Angeles to Hines; move communications circuits from an endpoint in Los Angeles to an endpoint in Hines; and move six FTEE from Los Angeles to Hines. This would reduce total FTEE by 38 from the present 44 in Los Angeles.

Only six FTEE would be required to bolster the existing Hines technical staff, because of the similarity in operation between the two sites. The increased computer workload would produce only a fractional increase in the total workload. No retraining would be involved because personnel would be performing the same tasks at Hines.

St. Paul DPC

Closing the St. Paul DPC and moving the service activities to the Austin DPC would involve the following: move the software and certain of the hardware from St. Paul to Austin and Philadelphia; and move 57 FTEE from St. Paul to Austin. This would reduce total FTEE by 58 from the present 115 in St. Paul.

The 57 positions, primarily applications programmers and auditors, are needed at the Austin DPC to support the transferred workload. It is also estimated that Austin can absorb some additional operational workload within their existing personnel resources. Minimal retraining would be involved in the relocation.

VADATS Romney Message Switching Center

Consolidate the ADP/message functions of both Romney and Austin MSCs at the Austin MSC. Minimal equipment movement is required. No augmentation of the Austin MSC staff is required, which would reduce MSC opeations by 17 FTEE.

While there are anticipated Fiscal Year 1986 closing costs, this approach achieves a permanent reduction of 113 FTEE and a part of the operating budget for each of the closed facilities. Cost savings will begin to be realized in Fiscal Year 1986. The costs would appear to be recovered in less than two years through reduced salary and operating costs for ODM&T.

A summary of the cost-savings to the government based upon current estimates are as follows:

ESTIMATED CONSOLIDATION DOLLAR SAVINGS PER YEAR

	Personal services	Space	Telephone [1]	Building maintenance	Total
St. Paul	1,522,000	[2]799,000	42,000	8,000	2,371,000
Los Angeles	1,108,000	[2]1,106,000	56,000	29,000	2,299,000
Romney	448,000	[3]220,000	1,000	([4])	668,000
	3,078,000	2,125,000	99,000	37,000	5,338,000

[1] Local telephone only.
[2] Begin in 1987.
[3] Begin in 1988.
[4] Included in Space.

Summary

Three alternatives are being used to reduce ODM&T operating costs. Productivity reviews and potential contracting out of ODM&T activities are expected to produce results in Fiscal Year 1988 and beyond. Attrition is expected to be used in Fiscal Year 1986 and beyond to translate productivity gains into cost savings. Independent of the preceding activities, consolidation of ODM&T activities will reduce operating costs in Fiscal Year 1986 and beyond. The basis for consolidation is generally as follows:

There are five DPCs operated by the Agency. Based upon budgetary and managerial consideration, the consolidation of activities is seen as necessary. It is not economically feasible to consider consolidating the very large operations at Hines and Austin to other locations, nor is it practical or feasible to relocate the insurance activities from Philadelphia.

(1) St. Paul is a relatively small operation dedicated primarily to CARS (Centralized Accounts Receivable System) support. The operation is configured for remote site processing and can be relocated easily, compared to other alternatives.

(2) The Los Angeles DPC performs functions compatible with other locations which could absorb this workload. Additionally, the operating and overhead costs in Los Angeles are comparatively high, and relocations of this facility will attain a savings greater than its proportionate size.

(3) The Romney operation is compatible with functions performed at Austin. It will be more efficient to combine these like functions, and the logical proposal is to shift the workload to the major network user which is the Austin DPC.

To implement the consolidation, a detailed technical and logistical consolidation plan is beng developed. The VA will meet all labor-management obligations and will offer available relocations opportunities to the affected employees, as well as establish an aggressive placement assistance program to ensure that they receive consideration for all suitable vacancies within the Agency. We will also establish referral contracts with other Federal agencies, State and local government and private sector organizations.

Question 2. The majority of computer processing work at the St. Paul DPC is done for the St. Paul Regional Office and Insurance Center which is located in the same building as the DPC and consists of Insurance and Debt Collection. What will be the impact of moving this work to Texas (over a thousand miles away from the users of the service)? Have you made a *detailed* plan which will assure that existing computer services will be maintained at the current or lower level of operating costs? What is the plan to keep the CARS unit operating effectively?

Answer. With current technology, the distance between users and their data processing support site is not an overriding concern. The St. Paul Data Processing Center's equipment is currently configured to support the Debt Collection Center as a remote site, even though they are located in the same building. Since the communications facilities are already in place, the lengthening of the distance between the sites does not present a technical challenge.

The VA is now developing the detailed plans for the move of the data processing support to Austin, and we anticipate no adverse impact upon the level of service provided to the CARS unit.

Question 3. We have heard only sketchy information on the proposed reorganization plan for VA regional offices. In view of the extensive computer support provided by the St. Paul DPC for the St. Paul Regional Office and the efficient working relationship between the two offices, isn't it premature to relocate the DPC before a final decision is made regarding the St. Paul Regional Office? For example, will the St. Paul Regional Office and Insurance Center remain intact and fully operational? Will a portion of its function be moved? Which operation will be moved? Will the Regional Office and Insurance Center be closed altogether?

Answer. A final decision on the St. Paul Regional Office is not a factor in the decision to relocate the Data Processing Center. The VA currently supports most of its Regional Office facilities from remotely located data processing centers. With current technology, the data processing support need not be co-located with the programmatic element. In view of this, we see no direct connection between the location of the data processing support for the St. Paul Regional Office and the fact that the VA is exploring the possible reorganization of VA Regional Offices. The future disposition of the St. Paul Regional Office and Insurance Center and its programmatic responsibilities will be addressed as plans are finalized fo the possible reorganization of the VA Regional Offices.

Question 4. Please provide specific cost requirements to operate the St. Paul DPC on a year-to-year basis which would allow the facility to remain in place until a decision regarding the Regional Office has been made.

Answer. Annual operating costs for the St. Paul DPC are approximately $6.1 million. This includes both FTEE and facility/equipment costs.

Question 5. It is my understanding that the VA does not have a sophisticated data network in place to transmit the information back and forth from the St. Paul Regional Office to the Austin DPC. When will this network be developed, how much will it cost, and has the cost been compared against the projected cost savings of relocating the St. Paul DPC? Will the user response time remain 1-2 seconds, providing a timely and prompt response on-the-spot? Will the daily crediting of both veterans' and government accounts be maintained?

Answer. The communications facilities are already in place to support Debt Collection as a remote site to the St. Paul data processing facility, even though it now happens to be located in the same building. In our preliminary analysis, we have considered the communication line costs for connecting users in the Regional Office to the Austin Data Processing Center, and those cost estimates will be refined as we develop our detailed plan. Such a communications facility can provide service to remote users that is virtually identical to the service expected by current local connections. We expect no change in the way the system operates.

Question 6. In the fall of 1984, the VA began planning for the renovation of the "old" Minneapolis VAMC Building 43 for occupancy by the St. Paul Regional Office and Insurance Center and the DPC as an effective use of VA-owned property. What happened to this idea?

Answer. Colocation continues to be a viable option and we have been actively pursuing this idea. Recently, the cost comparison study required by OMB Circular A-104 was completed for the St. Paul Regional Office and Insurance Center. Four options were considered in the study (build, renovate, continue to lease at present location, lease new space) and the determination made that the most economical and best choice would be to renovate Building 43 at the VAMC Minneapolis. We must note that the emphasis being placed on colocation efforts may be changed due to budget requirements and efforts to consolidate DVB operations.

Question 7. The VA operates five data processing centers in the U.S., only one of which occupies VA property, with the other four in GSA-leased space. How was the determination made to close the St. Paul DPC (on the basis of operating costs) instead of reducing operating costs and staffing at the other facilities on a prorated or shared basis? Is there any other DPC which brings in an average of $9 million dollars per month to the U.S. Treasury?

Answer. The preliminary analysis reveals that the cost per employee for operating the St. Paul and Los Angeles data processing centers is relatively high compared to the costs per employee at other DPCs. We examined contracting out, personnel reductions by attrition and closing facilities as means of reducing operating costs. Closing facilities was the only feasible alternative. The monies which come into the U.S. Treasury by the way of the St. Paul DPC are the result of applications which are run at that location. When the applications are moved to another location, the monies will continue to be collected.

Question 8. I understand that upgrading of the Austin DPC was accomplished with leased equipment, with those costs increasing each year, resulting in the need for the Austin workload to expand to cover the lease costs. Is the St. Paul operation being closed to accomplish this purpose?

Answer. The proposal to close the St. Paul DPC is not related to the equipment replacement effort conducted for the Austin DPC. The equipment replacement effort at the Austin DPC was conducted to support the known and anticipated production requirements of ADP applications located only at the Austin Data Processing Center.

Question 9. In 1983, the Department of Medicine and Surgery was delegated the authority for managing its non-centralized computer systems, setting precedent for operating such a system outside the auspices of ODM&T. Has thought been given to allowing the Department of Veterans Benefits the same autonomy? If so, wouldn't the St. Paul DPC more logically be aligned with the Veterans Benefits operations, since the user and computer systems are, for all practical purposes, one unit?

Answer. Debt collection is considered a centralized activity. There are no plans to establish a separate non-centralized activity. The St. Paul Activity is one of many DVB functions for which ODM&T provides direct processing support. Considering today's unlimited technical opportunities, there are no reasons why computer functions could not be provided from different sites.

Question 10. In 1981, VA Administrator Robert Nimmo stated that the St. Paul Regional Office and DPC was the center of expertise for the recovery of benefits overpayments. Since this joint operation has continued to perform an outstanding job of collecting money due the VA, why is the VA changing its previous policy, particularly in view of the computer enhancements and program support improvements that were provided to the DPC over the past three years?

Answer. Augmentations of the data processing capabilities of the St. Paul DPC over the past few years have been required to support enhancements to Debt Collection processing, particularly on-line processing over communications lines. With current technology, such data processing support does not have to be co-located with the programmatic element. In fact, the VA currently supports most of its Regional Office functions from remotely located data processing centers.

Question 11. I believe the VA is making plans to establish an agency-wide debt collection and accounts receivable function. In order to take full advantage of the expertise, experience, equipment and success of the only coordinated and consolidated debt collection unit now within the VA, why isn't St. Paul DPC being considered as the site for the new unit? Where will it be located and how much will establishing such a unit cost?

Answer. Consideration is being given to an Agency-wide debt collection and accounts receivable function in the form of a Debt Management Staff that will report directly to the Deputy Administrator. It will be created from existing resources and will continue to rely on an operating DPC for support of the application. Costs will be kept to an absolute minimum by utilizing current resources and facilities.

Question 12. Jack Sharkey of ODM&T told the St. Paul DPC staff earlier this month that, "I cannot argue that you probably have one of the highest personnel productivity rates of anywhere in the federal government." Is it good management policy to reward productive employees with the closing of their facility which has done an outstanding job of serving the VA and the federal government as a whole?

Answer. Mr. Sharkey believes that all VA DPCs have high productivity rates. The decision to close the St. Paul and Los Angeles DPCs was not made in the context of punishment or reward. The decision to close the St. Paul DPC was based upon good management policy aimed at reducing operating costs to the VA and federal government, while continuing to provide the current level of support to veterans.

CONGRESSMAN HARLEY STAGGERS TO VETERANS' ADMINISTRATION

The following questions are in reference to contracting out of counseling services for Vietnam Era veterans:

Question 1. Would it be possible for some of the money earmarked for the satellite centers to be used for the private contractors so they can provide more individual counseling services to the veterans?

Answer. No. Public Law 98-371, the FY 1985 HUD-Independent Agencies Appropriations measure, authorized an $8 million cap for the fee/contract component of the Readjustment Counseling Program. In addition, the Agency has earmarked $40.6, including the $8 million for fee/contract services, for Vet Center operational functions for FY 1985 and FY 1986. None of the operations monies are intended to be used for private counselors to provide more individual counseling services. The recent expansion will allow more of an opportunity for counseling services to be offered to veterans.

Question 2. It is my understanding that the Veterans' Administration does not allow the "advertising" of the availability of the contract counseling services. Is this true and if so what is the reason for the rule?

Answer. It is true that the private fee/contract providers are precluded from "advertising" the availability of their contract counseling services; however, generally through public service announcements or release of VA-generated press reports, communities are alerted that such services are available to eligible Vietnam era veterans. The reason we and not private fee/contract providers advertise is because this particular service is a "referral" program for Vietnam era veterans. The Agency manages the flow of referrals in concert with the amount of funding available within the communities throughout the country.

Question 3. it has been brought to my attention that there is a lot of administrative "red tape" involved in enrolling a veteran in the counseling programs. Can any of the paperwork be reduced, simplified or eliminated so that veterans will be more willing to use the service and providers will have less of an administrative headache?

Answer. The "red tape" is minimal in enrolling a veteran in the fee/contract counseling program. The veteran is simply required to meet face-to-face or discuss by telephone the reason he or she thinks readjustment counseling services are needed. Once the Vet Center staff or authorized VA Medical Center staff accomplish this brief interview, and criteria for referral are met, the Vietnam era veteran is authorized to be seen by the private counselor for up to three visits. During the three-visit assessment period, the private contractor must develop a treatment program that meets the clinical needs of the Vietnam era veteran, as far as resources permit. A maximum of 15 additional visits can be authorized by the VA referror and additional blocks of 15 visits can also be approved depending on need and availability of resources. We are continually seeking to find ways to improve the referral process. The Agency has begun to hire fee/contract monitors working out of local and regional Vet Center offices. One of their tasks will be to offer recommendations to VA Central Office that will have the effect of simplifying referral requirements.

Question 4. There seems to be a discrepancy between the reported average cost of providing contract counseling services to veterans and the payments made to the counseling center. The Veterans Administration reports the average cost of a counseling session is $60.00 per veteran per visit. The counseling center reports that they receive $50.00 for the initial intake interview and $18.75 for each group counseling session the veteran attends. Can you explain the difference in the figures?

Answer. The average cost of a counseling session provided by private counselors is between $45.00 and $50.00, while the cost per visit at a VA Vet Center is $31.00. When the veteran is seen during the three-visit assessment, that veteran is seen in individual therapy at an approximate cost of $50.00 per visit. There is fiscal incentive for private fee/contract providers to treat veterans in individual therapy over group therapy. The VA pays a maximum of 37.5 percent of the basic per-session reimbursement rate for each veteran. Group counseling sessions will be at least 90 minutes in length or may last longer. The average cost for group therapy is in the range of $18.00 to $20.00. It is more cost effective for Vietnam era veterans to be seen in group therapy, and the success rate of using this modality of treatment has a broad acceptance in the professional community. However, if there is clinical justification, individual, family, or vocational counseling will also be authorized for certain Vietnam era veterans.

The next series of questions refer to the satellite centers that will be opening to provide services to Vietnam Era Veterans:

Question 1. When will the Martinsburg Satellite Center be opening and fully operational?

Answer. The Martinsburg Satellite Center should be open and operational by July 1985.

Question 2. When will the Charleston Satellite Center be opening and fully operational?

Answer. The Charleston Satellite Center is now seeing clients; however, the official opening of this Satellite Center is still in the planning stages, and your office will receive an invitation to participate in the opening at a later date. The center is located at 1105 Quarrier Street, Charleston, West Virginia 25301. The telephone number is (304) 343-3825.

Question 3. How will these centers be staffed? Will they be staffed by Vietnam veterans or professional counselors? What are the advantages and disadvantages of each? Will the employees be full-time or part-time and how many people will be on the staff of each center?

Answer. At least one Department of Medicine & Surgery mental health professional will be hired to staff each of these offices. Additional staffing patterns will also accommodate the hiring of at least two Vietnam veterans in each office. An immediate advantage would be that the center could offer clinical intervention and the staff, given they are Vietnam veterans, would have a thorough understanding of the Southeast Asia experience. However, a disadvantage would be a possible delay in finding people who possess clinical degrees and also happen to be Vietnam veterans. In addition, we plan to hire full-time employees for these counseling centers.

Question 4. Many of the veterans in my district will have to travel quite some distance to use the services offered. Will any arrangements be made to defray the cost of their travel to and from the satellite centers?

Answer. For those veterans who live a great distance from the closest Vet Center (in excess of 50 miles), we will continue to offer readjustment counseling services through private fee/contract providers throughout the State of West Virginia. There are no plans to defray the cost of their travel to and from the satellite centers.

Question 5. Will counseling services be available only at the satellite centers or will the staff members travel to different areas to provide services on a local level?

Answer. Counseling services will be offered at the centers, and the respective staffs will also travel to other areas of the state on a regular basis in order to provide community outreach.

The following questions are in reference to the proposed closure of the Message Switching Center in Romney, West Virginia:

Question 1. My constituents have expressed great concern about this proposed closure. How much money do you anticipate will be saved by closing this facility?

Answer. The VA anticipates a savings of $630,000 in FY 1986 by closing the message switching function at Romney. Savings of this magnitude and more will be realized in out years.

Question 2. What will be the impact on services if the facility is closed?

Answer. Because of the changes in telecommunications technology there will be no impact on users of the VA Data Transmission System (VADATS) as a result of closing the Romney message switching function.

Congressman STAGGERS. I would like to urge that this center be maintained at its present level as the closure will result in increased economic hardship in an area already facing economic adversity.

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